Maryland
STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 5 *October, 1956* NUMBER 10

CONCLUSION OF 1956 TRANSACTIONS

One Hundred Fifty-Eighth Annual Meeting

Baltimore, Maryland

Wednesday, Thursday, Friday, May 2, 3, 4, 1956

BUSINESS SESSIONS

Wednesday, Friday, May 2, 4, 1956

CONTINUATION OF REPORTS
PRESENTED TO THE HOUSE OF DELEGATES
MAY 2, 4, 1956

TRANSACTIONS FOR 1956

Please see MARYLAND STATE MEDICAL JOURNAL

Volume 5, No. 8, August 1956, Scientific Papers and Membership Roster
Volume 5, No. 9, September 1956, Scientific Paper, Minutes of House of Delegates Meetings and Reports
Volume 5, No 10, October 1956, Completion of Reports

Conclusion of Transactions

Completion of 1956 Committee Reports*

COMMITTEE TO COOPERATE WITH THE AMERICAN EDUCATION FOUNDATION (1955)

Mr. President and Members of the House of Delegates:

As a result of one circularization authorized by the Medical and Chirurgical Faculty, the amount contributed was $3,579.00. The total amount for the year was $24,179.00, which would demonstrate the effectiveness of even limited mail solicitation. However, Committee hands are tied in such important work by the fact that it took several months to get official authorization for one letter which produced such good results.

It is to be hoped that Maryland will officially see its responsibility of such a vital program which individuals have already acknowledged.

Respectfully submitted,

Newland E. Day, M.D., *Chairman*
Thurston R. Adams, M.D.
Walter A. Baetjer, M.D.
John G. Ball, M.D.
J. Herbert Bates, M.D.
Katherine A. Chapman, M.D.
Stuart Christhilf, Jr., M.D.
H. Vincent Davis, M.D.
L. E. Daugherty, M.D.
Wilfred W. Eastman, M.D.
Charles R. Foutz, M.D.
Wylie M. Faw, Jr., M.D.
William B. Hagan, M.D.
L. A. Hoffman, M.D.
Philip A. Insley, M.D.
Ernest F. Poole, M.D.
Paul H. Royse, M.D.
Theodore R. Shrop, M.D.
Milford H. Sprecher, M.D.
(1955 Committee)

COMMITTEE TO COOPERATE WITH THE AMERICAN EDUCATION FOUNDATION (1956)

Mr. President and Members of the House of Delegates:

This Committee was reconstituted on 10 January, 1956 with the following membership:

Dr. John T. B. Ambler, Easton; Dr. Wylie M. Faw, Jr., Cumberland; Dr. William B. Hagan, Mt. Rainier; Dr. L. A. Hoffman, Hagerstown; Dr. Philip A. Insley, Salisbury; Dr. James R. Martin, Annapolis; Dr. A. Austin Pearre, Frederick; Dr. Ernest F. Poole, Hagerstown; Dr. Paul H. Royse, Pikesville.

The first official act of the reconstituted committee was the attendance by the Chairman of the American Medical Education Foundation Fifth Annual Meeting of State Chairman in Chicago 22 January, 1956. The meeting was opened by an address of welcome by Louis H. Bauer, M.D., President, American Medical Education Foundation followed by a discussion of the relationships of the AMA and the medical schools by Elmer Hess, M.D., President, American Medical Association. The remainder of the meeting was devoted to summarizing the work of the foundation during the past year and presenting plans for the coming year. During the period January 1, 1955 through December 31, 1955 $757,163.29 was raised by the fund. This was less than the preceding year due to the reduction of the AMA contribution to $100,000. The amounts raised are far short of the ten million dollar goal. In fact, the contributions from doctors have averaged so low that one corporation that had been contributing $50,000 annually had withdrawn its gift on the basis that if doctors did not have faith in the needs for medical education that industry could not be expected to support the foundation. This led to a discussion of how to get greater participation by physicians in supporting the fund. The number of physicians contributing to the fund amount to only about 10% with 90% not contributing. Because of this, Illinois and California have made contributions of $10.00 and $20.00 a part of state dues and they advocated that other states follow suit. In addition, the AMA has been requested to consider adding an annual assessment to support medical education to the AMA dues. This is now under consideration.

The reconstituted committee met on 23 February. Present: Drs. John T. B. Ambler, Easton, Wylie M. Faw, Jr., Cumberland, Ernest F. Poole, Hagerstown, Paul H. Royse, Pikesville, and William S. Stone, Baltimore.

It was decided to carry out this year's campaign as follows:

1. Utilize County and City Medical Society Committees to present the needs of the Medical Education Foundation to the individual physicians.

2. To set a state goal of $25,000 for Physician contributions to the Foundation.

3. To conduct an intensive drive for funds May 1 to May 14, 1956.

During 1955 only 258 Maryland physicians contributed to the National Medical Education Foundation. There are over 2500 physicians in active practice in the State. Therefore, only a little over 10% of physicians are supporting medical education through the National Medical Education

* See also September 1956 Maryland State Medical Journal, Vol. 5, No. 9

Foundation. If the total contribution from Maryland physicians to the fund during 1955 ($4,692.00) was prorated to all practicing physicians in Maryland, it would mean that only $1.90 per physician was contributed. The actual amount needed is $10.00 per physician and the committee hopes that many could see fit to assist medical education with more than that amount. The committee feels that if voluntary contributions cannot be obtained in adequate amount, medical education will suffer and steps such as those in Illinois and California may become necessary.

Respectfully submitted,
WILLIAM S. STONE, M.D., *Chairman*
JOHN T. B. AMBLER, M.D.
WYLIE M. FAW, JR., M.D.
WILLIAM B. HAGAN, M.D.
L. A. HOFFMAN, M.D.
PHILIP A. INSLEY, M.D.
JAMES R. MARTIN, M.D.
A. AUSTIN PEARRE, M.D.
ERNEST F. POOLE, M.D.
PAUL H. ROYSE, M.D.
(1956 Committee)

ARMY MEDICAL LIBRARY COMMITTEE (1955)

Mr. President and Members of the House of Delegates:

No meeting of this Committee was held during 1955.

Respectfully submitted,
ANDREW C. GILLIS, M.D., *Chairman*
LOUIS KRAUSE, M.D.
JOHN E. SAVAGE, M.D.
LAWRENCE R. WHARTON, M.D.
(1955 Committee)

ARMY MEDICAL LIBRARY COMMITTEE (1956)

Mr. President and Members of the House of Delegates:

This Committee was appointed in 1940. Its purpose was to foster interest in the Army Medical Library in Washington and to bring to the attention of the medical profession in the state every effort possible to provide safe and adequate housing for this renowned collection of books. The Committee had not met for several years.

The present Chairman of the Committee visited the library and met with the Director, Lt. Col. Frank B. Rogers. He is anxious that the membership of the Medical and Chirurgical Faculty be acquainted with this fine collection of books and give vocal support whenever possible toward improvement of the library facilities.

The membership of the Committee was polled, and it was decided that the functions of this Committee could be taken over by our Library Committee.

THEREFORE, THE PRESENT ARMY MEDICAL LIBRARY COMMITTEE RECOMMENDS: THAT THE COMMITTEE BE DISCHARGED AND ITS ACTIVITY ASSUMED BY THE LIBRARY COMMITTEE.

Respectfully submitted,
J. ROY GUYTHER, M.D., *Chairman*
HENRY J. L. MARRIOTT, M.D.
MAURICE C. PINCOFFS, M.D.
LAWRENCE R. WHARTON, M.D.
(1956 Committee)

BLOOD BANK ADVISORY COMMITTEE (1955)

Mr. President and Members of the House of Delegates:

This Committee has no report for the calendar year 1955. There were no meetings of the Committee and no items of business considered.

Respectfully submitted,
JOHN WHITRIDGE, JR., M.D., *Chairman*
C. LOCKARD CONLEY, M.D.
JULIUS R. KREVANS, M.D.
KENDRICK MCCULLOUGH, M.D.
WALTER C. MERKEL, M.D.
VERNON H. NORWOOD, M.D.
MILTON S. SACKS, M.D.
BENEDICT SKITARELIC, M.D.
MERRELL L. STOUT, M.D.
(1955 Committee)

BLOOD BANK ADVISORY COMMITTEE (1956)

Mr. President and Members of the House of Delegates:

Negative.

Respectfully submitted,
MILTON S. SACKS, M.D., *Chairman*
C. LOCKARD CONLEY, M.D.
JULIUS R. KREVANS, M.D.
KENDRICK MCCULLOUGH, M.D.
WALTER C. MERKEL, M.D.
VERNON H. NORWOOD, M.D.
H. RAYMOND PETERS, M.D.
ISADORE A. SIEGEL, M.D.
BENEDICT SKITARELIC, M.D.
CARROLL L. SPURLING, M.D.
JOHN WHITRIDGE, JR., M.D.
(1956 Committee)

BUDGET COMMITTEE

Mr. President and Members of the House of Delegates:

The Budget Committee appointed by Dr. Warfield M. Firor, Chairman of the Council, met on March 22, 1956, and considered a proposed budget based upon the current estimations of income anticipated for 1956. This budget was transmitted to the Council with recommendation for its acceptance.

Following this, in view of the needs for additional services which were brought to the attention of the Council, the Budget Committee and the Finance Committee met together. The report of this joint meeting was considered by the Council at its meeting on April 24, 1956.

See "Fiscal Facts."

Following the budget are statements "Showing Functional Breakdown of Budget" and "Actual and Estimated Expenses."

Respectfully submitted,
E. COWLES ANDRUS, M.D., *Chairman*
BENDER B, KNEISLEY, M.D.
RICHARD C. DODSON, M.D.
WETHERBEE FORT, M.D.
NORMAN E. SARTORIUS, JR., M.D.

1956 TENTATIVE BUDGET

ESTIMATED INCOME

From Dues		
Baltimore City members	$53,555.00	
County members	27,695.00	$81,250.00
Baltimore City Medical Society		
For use of facilities	400.00	
For secretarial services	3,100.00	3,500.00
Baltimore City Dental Society		
475 members at $3.00		1,425.00
State Board of Medical Examiners		
Rental for 1215 Cathedral Street	1,680.00	
Rental for use of Osler Hall	480.00	2,160.00
State Board of Nurses Examiners		
Rental for Osler Hall		180.00
State Nurses Association		
Rental for 1217 Cathedral Street		2,000.00
Maryland League for Nursing		
Rental for 3rd Floor, 1215 Cathedral Street		360.00
State Veterinarian Board		50.00
Income from Invested Funds		
For General Purposes		
Bowen Fund	$955.00	
Bressler Fund	195.00	
Contingent Fund	325.00	
Ellis Fund	485.00	
Osler Endowment Fund	150.00	
Osler Testimonial Fund (½)	417.00	
Hiram Woods Fund	245.00	2,772.00
For Special Purposes		
Beck Fund	115.00	
Cordell Fund	395.00	
Finney Fund (½)	450.00	
Friedenwald Fund	80.00	
Stokes Fund (½)	165.00	
Trimble Fund	285.00	1,490.00

For Library Purposes		
Baker Fund	70.00	
Barker Fund	40.00	
Cowles Fund	80.00	
Finney Fund (½)	450.00	
Frick Fund	1,610.00	
Harlan Fund	80.00	
McCleary Fund	80.00	
Osler Testimonial Fund (½)	417.00	
Ruhräh Fund	4,375.00	
Stokes Fund	165.00	7,367.00
Income from Annual and Semiannual Meetings		7,115.00
Income from Journal		
From Advertising	24,100.00	
From Subscriptions	200.00	24,300.00
Total Estimated Income		$133,969.00

ESTIMATED DISBURSEMENTS

1956 BUDGET

1. Auditor	$600.00
2. Committee Expenses	750.00
3. Communication	3,400.00
4. Contributions	100.00
5. Fuel	3,000.00
6. Gas, Electricity and Water	2,400.00
7. Household and Janitorial Supplies and Expenses	1,000.00
8. Insurance	1,400.00
9. Journal Expenses	27,000.00
10. Legal Fees	1,500.00
11. Library, Books, Binding, Supplies, etc.	7,367.00
12. Maintenance of Property	1,800.00
13. Meetings, Annual and Semiannual	9,800.00
14. Miscellaneous	3,400.00
15. Office Equipment	650.00
16. Office Supplies	1,762.00
17. Printing	1,450.00
18. Salaries	61,000.00
19. Taxes	2,600.00
20. Travel	1,400.00
21. Legislative Expense	100.00
22. Special Accounts (per contra)	1,490.00
Total Estimated Disbursements	$133,969.00

W. N. K.

STATEMENT SHOWING FUNCTIONAL BREAKDOWN OF BUDGET

	Payroll & P/R Taxes	Materials Services etc.	Total	% of Total Revenues	Funds Provided By		% Of Dues Revenues	
					Specific Revenues	Dues		
1955 Actual Expenditures								
Administrative	$12,300.	5,300.	17,600.	13%	—	17,600.	21%	
Office	24,700.	21,000.	45,700.	34%	11,700.	34,000.	40%	78%
Building	9,900.	11,000.	20,900.	16%	6,600.	14,300.	17%	
Library	10,700.	6,700.	17,400.	13%	7,400.	10,000.	12%	22%
Journal	3,700.	28,700.	32,400.	24%	24,300.	8,100.	10%	
Total	61,300.	72,700.	134,000.	100%	50,000.	84,000.	100%	

(*Continued on next page*)

STATEMENT SHOWING FUNCTIONAL BREAKDOWN OF BUDGET—*Continued*

	Payroll & P/R Taxes	Materials Services etc.	Total	% of Total Revenues	Funds Provided By		% Of Dues Revenues	
					Specific Revenues	Dues		
1956 Estimated Budget Based on Present Income								
Administrative	$13,500.	5,100.	18,600.	14%	—	18,600.	23%	
Office	24,000.	22,700.	46,700.	35%	14,400.	32,300.	40%	77%
Building	10,000.	8,200.	18,200.	13%	6,600.	11,600.	14%	
Library	12,500.	7,400.	19,900.	15%	7,400.	12,500.	15%	23%
Journal	3,600.	27,000.	30,600.	23%	24,300.	6,300.	8%	
Total	63,600.	70,400.	134,000.	100%	52,700.	81,300.	100%	
1956 Estimated Budget Based on Required Expenses								
Administrative	$14,700.	7,600.	22,300.	14%	—	22,300.	20%	
Office	35,500.	25,200.	60,700.	37%	14,400.	46,300.	42%	78%
Building	11,200.	13,300.	24,500.	15%	6,600.	17,900.	16%	
Library	14,300.	7,400.	21,700.	13%	7,400.	14,300.	13%	22%
Journal	4,000.	30,000.	34,000.	21%	24,300.	9,700.	9%	
Total	79,700.	83,500.	163,200.	100%	52,700.	110,500.	100%	

J. M.

ACTUAL AND ESTIMATED EXPENSES

	1955 Actual Expenses	1956 Estimate—Present Income	1956 Estimated Increase in Expenses	1956 Estimated—Required Expenses
1. Auditor	$508.13	$600.00	—	$600.00
2. Committee Expense	948.93	750.00	$250.00	1,000.00
3. Communication	3,410.59	3,400.00	200.00	3,600.00
4. Contributions	100.00	100.00	—	100.00
5. Fuel	2,756.57	3,000.00	100.00	3,100.00
6. Gas, Electricity & Water	2,313.72	2,400.00	100.00	2,500.00
7. Household & Janitorial Expense	1,086.87	1,000.00	200.00	1,200.00
8. Insurance	1,645.40	1,400.00	100.00	1,500.00
9. Journal Expense	28,714.33	27,000.00	3,000.00	30,000.00
10. Legal Fees	1,702.39	1,500.00	1,000.00	2,500.00
11. Library, Books, etc.	6,705.77	7,367.00	—	7,367.00
12. Maintenance of Property	1,825.49	1,800.00	700.00	2,500.00
13. Meetings—Annual and Semiannual	9,765.60	9,800.00	200.00	10,000.00
14. Miscellaneous	3,394.28	3,400.00	200.00	3,600.00
15. Office Equipment	307.82	650.00	350.00	1,000.00
16. Office Supplies	1,749.76	1,762.00	238.00	2,000.00
17. Printing	1,413.19	1,450.00	50.00	1,500.00
18. Salaries	58,501.56	61,000.00	13,140.00	74,140.00
19. Taxes	2,669.43	2,600.00	900.00	3,500.00
20. Travel	1,112.26	1,400.00	1,200.00	2,600.00
21. Legislative Expense	294.26	100.00	200.00	300.00
22. Extra Repairs and Improvements	2,007.32	—	3,000.00	3,000.00
23. New Equipment for Buildings	996.74	—	1,000.00	1,000.00
24. Transactions		—	1,000.00	1,000.00
25. Special Accounts		1,490.00	—	1,490.00
26. Fringe Benefits		—	2,100.00	2,100.00
	$133,930.41	$133,969.00	$29,228.00	$163,197.00

W. W. K.

COMMITTEE ON CONSTITUTION AND BY-LAWS

Mr. President and Members of the House of Delegates:

The Council has referred to our Committee several suggested amendments to the Constitution and By-Laws. Chapter XI, of the By-Laws, under Amendments, states: "These By-Laws may be amended at any Annual Meeting by a majority vote of all the delegates present at that session, after the amendment has laid on the table for one day;" our Committee, therefore, will first present these suggested amendments to the House of Delegates on Wednesday morning, May 2, 1956, and for final action, to the House at its meeting on Friday morning, May 4, 1956.

Our Committee suggests that the following amendments to the By-Laws be adopted.

BY-LAWS

(Amendments are indicated by CAPITAL LETTERS and PARENTHESIS are for deletions.)

EXPLANATION. In order that Associate Members as well as Active Members may obtain non-resident membership status when they leave the State of Maryland, the following change would have to be made in Chapter I, Section 6, which reads as follows and the parenthesis indicates the omission of the word "Active."

CHAPTER I—MEMBERSHIP

SECTION 6. *Non-Resident Members*

Non-Resident Members shall be such (Active) Members as have removed from the State and wish to retain their affiliation with the Faculty of Maryland.

OUR COMMITTEE THEREFORE RECOMMENDS THAT THE WORD "ACTIVE" BE DELETED FROM CHAPTER I, SECTION 6 OF THE BY-LAWS.

EXPLANATION (for Chapter VI, Section 5 and Chapter VIII, Section 7). As the Treasurer has always served as the Chairman of the Finance Committee and as this body is now designated in the By-Laws, the Council suggested that the necessary inclusions be made and our Committee agreed. THE COMMITTEE ON CONSTITUTION AND BY-LAWS RECOMMENDS THAT THE CHAIRMAN OF THE FINANCE COMMITTEE BE THE TREASURER AND THESE TWO SECTIONS OF THE BY-LAWS WILL READ AS FOLLOWS, (THE AMENDMENT IS IN CAPITAL LETTERS):

CHAPTER VI—DUTIES OF OFFICERS

SECTION 5. *Treasurer*

The Treasurer shall BE THE CHAIRMAN OF THE FINANCE COMMITTEE. HE SHALL give bond in the sum to be fixed by the Council, the premium on which shall be paid by the Faculty. He shall demand and receive all funds due the Faculty, together with the bequests and donations. He shall pay money out of the Treasury only as directed by the House of Delegates or the Council. He shall subject his accounts to such examination as the House of Delegates may order, and he shall render yearly to the House of Delegates an account of his activities and of the state of the funds in his hands. He shall pay the vouchers of the Library Committee not to exceed the amount of the annual appropriation made by the House of Delegates for the support of the library.

CHAPTER VIII—STANDING COMMITTEES

SECTION 7. *Finance Committee*

It shall be the duty of the Finance Committee to act as such for the House of Delegates and FOR the Council. It shall consist of five members, namely, the Chairman of the Council, the Treasurer, WHO SHALL ALSO BE THE CHAIRMAN OF THE COMMITTEE, the Secretary, and two members of the Faculty appointed by the Chairman of the Council. The Finance Committee shall cooperate with the Budget Committee in the preparation of the annual budget for the Faculty.

EXPLANATION (for Chapter VII, Section 6-(a)). The request for an omission of the last phrase of this section is as a result of a suggestion by Mr. G. C. A. Anderson, our legal counsel, and the Council has requested our Committee to implement it. THEREFORE, THE COMMITTEE ON CONSTITUTION AND BY-LAWS RECOMMENDS THE DELETION OF THE FOLLOWING, (noted in parenthesis):

CHAPTER VII—THE COUNCIL

SECTION 6.—*Conditions*

(a) Any member desiring to avail himself of the provisions of this section shall, as soon as possible after any demand has been made upon him or any suit instituted against him, present to the Council his request for defense and, together therewith, a full and complete history of the case, the services rendered and his further connection with or relationship to the plaintiff; and if the Council decides that his grounds of defense are valid, he shall vest in the Council authority to assist in the defense of said claim or suit (*and agree to make no compromise or settlement of the matter without the consent of the Council given in writing and signed by its proper officers.*)

EXPLANATION (for Chapter VIII, Section 9). The Committee would like to suggest revising the words relating to the Resolutions Committee. This does not change thought or meaning, but we think improves the English, and THEREFORE THE COMMITTEE RECOMMENDS THAT THIS SECTION BE WRITTEN AS FOLLOWS:

CHAPTER VIII—STANDING COMMITTEES

SECTION 9.—*Resolutions Committee*

The Resolutions Committee shall consist of five members to be appointed annually by the President of the Medical and Chirurgical Faculty, who shall also designate the Chairman of the Resolutions Committee. This Committee shall be chosen from the House of Delegates, and shall be appointed at least 30 days before the Annual Meeting of the House of Delegates.

Any new business involving a question of policy, which has not previously been considered by the Council or the House of Delegates, shall be referred to the Resolutions Committee for consideration, before being acted on by the House of Delegates. Any such new business shall be presented in writing to the Secretary of the

Faculty at least 8 weeks prior to the Annual or Semi-Annual Meeting whichever happens to be concerned.

All proposed resolutions shall be referred to the Resolutions Committee WHICH Committee shall present them to the House of Delegates with its recommendations (as to) FOR approval, disapproval or FOR recommittal to the sponsor for revision with the recommendations of the Resolutions Committee. If the Resolutions Committee approves the principle of a proposed resolution but not the form of ITS expression, it shall have the authority to submit to the sponsor a (revised) REVISION (resolution) which, if ACCEPTABLE TO THE SPONSOR (agreed to by the sponsor), may be presented to the House of Delegates by the Resolutions Committee.

The Council may refer to the Resolutions Committee all recommendations that should be formulated as resolutions before presentation to the House of Delegates with an expression of opinion by the Council as to the policy involved therein.

WHEN REQUESTED BY THE PRESIDING OFFICER OF THE HOUSE OF DELEGATES, the Resolutions Committee shall report to the House of Delegates, (at the time indicated by the Chairman).

Respectfully submitted,
W. Houston Toulson, M.D., *Chairman*
E. Cowles Andrus, M.D.
Charles R. Austrian, M.D.
Thurston Harrison, M.D.
Donald Hooker, M.D.
William S. Love, M.D.
Albert Richard Milan, M.D.
John Young, Jr., M.D.

EUGENE FAUNTLEROY CORDELL FUND COMMITTEE (1955)

Mr. President and Members of the House of Delegates:

I know of no activities of this Committee in 1955.

Respectfully submitted,
T. Nelson Carey, M.D., *Chairman*
James K. Gray, M.D.
William L. Howard, M.D.
James P. Miller, M.D.
Frank F. Lusby, M.D.
George Allen Moulton, Jr., M.D.
(1955 Committee)

EUGENE FAUNTLEROY CORDELL FUND COMMITTEE (1956)

Mr. President and Members of the House of Delegates:

There have been no requests for financial assistance from this Fund during the past year.

In the 1954 report the cash balance indicated was $1,543.91, but there was an additional amount of income of $39.62 which was not distributed until 1955. The money invested from the accumulated income, $4,127.07, was not listed. For 1954 the correct balance was $5,710.60.

The financial status of the Eugene Fauntleroy Cordell Fund is as follows:

There were no beneficiaries during 1955.	
Balance on Hand, January 1, 1955	$5,710.60
Income on Principal	391.16
Income on accumulated income (invested)	188.38
Interest	43.46
Balance on Hand, December 31, 1955	$6,333.60

Respectfully submitted,
W. Oliver McLane, Jr., M.D., *Chairman*
Royal A. Bell, M.D.
H. Vincent Davis, M.D.
Charles J. Foley, M.D.
William B. Long, M.D.
James T. Marsh, M.D.
(1956 Committee)

CURATOR

Mr. President and Members of the House of Delegates:

During the past year, several gifts have been received by the Medical and Chirurgical Faculty. Among them is a Tent Desk which belonged to Dr. William Hilleary, one of the Faculty founders, and which was used in the War of 1812. The desk was bequeathed to the Faculty by Miss Mary Louise Johnson, the sister of Dr. Thomas B. Johnson, who was elected to serve as President of the Faculty for 1926 but who died December 25, 1925.

Dr. John F. Hogan, Sr., gave the Faculty a beautiful case of medical instruments which belonged to Dr. F. W. Robertson.

Dr. Wetherbee Fort gave us a goldheaded cane which had belonged to Dr. L. Ernest Neale, who was a member of this Society until his death in 1834.

John M. Hyson, D.D.S., has given us a saddle bag which belonged to his Great Uncle. He has also given us an old Medical Diploma of Dr. John M. Hyson, a graduate of the Baltimore Medical College.

Dr. Harry C. Hyde gave us a large portrait of Dr. David Meredith Reese, (1778–1865) an honorary member of the Medical and Chirurgical Faculty. Dr. Hyde also gave us some interesting notes of Dr. Reese, and a rare old book.

Dr. J. Albert Chatard took a keen interest in collecting memorabilia for the Medical and Chirurgical Faculty, and several years ago the Council appointed him Curator. The Executive Committee will make recommendations to the Council for an appointment for this position, vacated by the death of Dr. Chatard.

Respectfully submitted,
Everett S. Diggs, M.D., *Secretary*

COMMITTEE ON DIABETES

Mr. President and Members of the House of Delegates:

During Diabetes Week, November 14–20, 1955, a special effort was made throughout the State for the detection of the unknown diabetic. The following methods of detection were employed.

1. Detection centers for testing both blood and urine.
2. Utilization of Health Department Clinics where urine specimens were brought in by the individual.
3. Specimens brought to a local physician and examination for sugar made at no charge.
4. Distribution of St. Louis Dreypaks by drugstores and returned to a detection center.

Results of Screening Tests:

1. Number of positive tests of previously unknown diabetics as shown by blood and urine examinations—*201.*
2. Number of previously unknown diabetics as shown by urine test only—*51.*
3. Total number tested:

Urine (only)	1,614
Blood & Urine	2,785
	4,399

The above figures do not include the specimens examined by the local physicians in their offices as the results of these incidents were not kept and forwarded to the Committee.

Positive results in all cases were forwarded to the persons' physician of choice for further study. It is believed that a number of these individuals will prove not to be diabetics. The results of the additional study would be very valuable to the Committee but many physicians have been delinquent in returning their conclusions.

Active participation with written reports were received from Baltimore City, Frederick, Baltimore, Calvert, Caroline, Cecil and Saint Mary's counties. Other sections of the State participated but reports have not been received. This Drive has remained unique in that it has not been a fund raising campaign. Its conduction and success has been entirely dependent on volunteer assistance. The Committee wishes to express its appreciation of the untiring efforts of the following: Maryland Dietetic Association, Maryland Association of Hospital Auxiliaries, Maryland Pharmaceutical Association, Baltimore Retail Druggist Association, Baltimore City and Maryland State Departments of Health, Maryland Tuberculosis Association, 104th Medical Battalion-Maryland National Guard, United States Public Health Service, American Diabetes Association and the newspapers and radio and television stations.

The Committee feels most encouraged by the distribution of activity over a wide area of the State. Recognizing the seriousness of the diabetes problem, it is hoped that detection activities can gradually gain the full cooperation of the medical profession.

Respectfully submitted,

J. Sheldon Eastland, M.D., *Chairman*
Edmund G. Beacham, M.D.
Charles J. Blazek, M.D.
Ernest C. Brown, Jr., M.D.
Caroline H. Callison, M.D.
James D. Carr, M.D.
Henry V. Chase, M.D.
Edward F. Cotter, M.D.
J. Wilfrid Davis, M.D.
Edward J. Edelen, M.D.
J. Roy Guyther, M.D.
W. Grafton Hersperger, M.D.
Philip W. Heuman, M.D.
Seth H. Hurdle, M.D.
Samuel M. Jacobson, M.D.
Benjamin F. Jones, M.D.
J. Elliot Levi, M.D.
George Allen Moulton, Jr., M.D.
Charles F. O'Donnell, M.D.
Margaret V. Palmer, M.D.
Sarah M. Peyton, M.D.
Harold B. Plummer, M.D.
J. Emmett Queen, M.D.
George Sharpe, M.D.
Charles E. Shaw, M.D.
Frank M. Shipley, M.D.
Theodore R. Shrop, M.D.
Abraham A. Silver, M.D.
Willard F. Smith, M.D.
Stanley R. Steinbach, M.D.
Samuel J. N. Sugar, M.D.
Nathaniel R. Thomas, M.D.
James U. Thompson, M.D.
Alice Berg Tobler-Lennhoff, M.D.
W. Alfred Van Ormer, M.D.
Lester A. Wall, Jr., M.D.
George Jones Weems, M.D.

MARYLAND STATE MEDICAL JOURNAL, EDITOR

Mr. President and Members of the House of Delegates:

During the past year commemorative issues have been published by Dorchester County, January 1956; Baltimore County, March 1955; Fort Howard Hospital, April 1955; Woman's Hospital, June 1955; Lutheran Hospital, July 1955; Bon Secours Hospital, October 1955; Frederick County, November 1955, and Baltimore City Hospitals, December, 1955.

There has been an abundance of material available for publication. Very satisfactory secretarial and administrative assistance have been available during the past year.

An attempt has been made to develop more attractive mastheads by appropriate illustrations. During the coming year, it is hoped that all permanent sections of the Journal can be assigned permanent and attractive mastheads.

Respectfully submitted,

George H. Yeager, M.D., *Editor*

GERIATRICS COMMITTEE (1955)

Mr. President and Members of the House of Delegates:

The outstanding accomplishment of the Committee for the year 1954–55 was the bringing to the City of Baltimore the 8th Annual Convention of the Gerontologic Society of America. This Convention took place in our City on October 27, 28, 29 at the Sheraton-Belvedere Hotel.

The Chairman of your Committee traveled to Gainsville, Florida, December 1954 to the 7th Annual Convention of the

above organization to extend to them the invitation to bring their 8th Convention to our City. This has been with the approval and consent of the officers of the Baltimore City Medical Society as well as the Medical Chirurgical Faculty.

One of the characteristic features of the Gerontologic Society of America is that it is not limited to members of the medical profession. It started out from the premise that the problems on Aging are not confined to medicine alone. That aging involves many physical and social phenomena. Therefore, the biochemist, the physiologist, the biologist are very much concerned with the factors which cause the changes in the animal body that we recognize as aging. And, furthermore, the problems are not limited merely to the physical phases of the process but that it reaches out to many activities that make up human life and existence. These include the social workers, the educators, the rehabilitationists, community workers, etc.

The Gerontologic Society therefore, is composed of representatives of these various scientific and social disciplines. And, when the Committee found itself engaged in the job of preparing and organizing for the Convention it was deemed proper that all the other segments in the community concerned in one way or another in the processes of aging and in the well being of the aged, should be invited. We are happy to register our great satisfaction with the response and cooperation the Committee received from these various elements in the community of Baltimore. The Convention Committee therefore, consisted not only of physicians but also of representative members of the Department of Public Welfare, the Health Department, the Social Workers in the community, Adult Education Department of the Public School System, representatives of the various institutions for the Aged and a few governmental departments concerned with Social Security and old age relief and housing. It was a stimulating community experience to have all these representatives joined together in this venture.

In the eight years of its existence the Gerontologic Society of America has gained for itself a respectable position in the world of medical sciences as well as with the social disciplines. It has to its credit notable accomplishments in scientific research as well as in the organizing of various segments of the community in behalf of the Aging population.

The local medical profession has responded warmly to the presence of the Convention and there were at least three events in which the program has been participated in by the members of the local profession jointly with the delegates of the Convention. These were a joint meeting of the delegates with the members of the Academy of General Practitioners of Maryland which took place in the afternoon of Thursday the 27th of October. This meeting was presided over by Professor Louis A. M. Krause and there was a program of clinical interest presented by Professors J. Finesinger and C. R. Edwards of the University of Maryland and Dr. F. D. Zeman of New York and Dr. M. Ferderber of Pittsburgh, delegates to the Convention. This meeting was very well attended. It crowded the meeting room to capacity.

On the same evening there was a reception to the delegates at Osler Hall, in the Faculty Building on Cathedral Street. The reception was in the form of an interesting program the theme of which was "Medical Education for Gerontology." Dr. George H. Yeager presided over the meeting, Dr. Amos R. Koontz greeted the delegates in the name of the Baltimore City Medical Society. Dr. Maurice Pincoffs addressed the gathering in behalf of the Medical School of the University of Maryland and Dr. Tilghman Carmichael brought greetings from the Johns Hopkins Medical School. Dr. F. C. Swartz, East Lansing, Michigan, was guest speaker for the evening and presented a very interesting paper on the "General Aspects of Gerontology." This gathering was followed by a social hour during which the delegates and the local physicians chatted freely on topics of interest to medicine and allied problems. On Saturday morning the medical delegates to the Convention took advantage of the Grand Rounds at Hopkins and a considerable number of them left other activities for that program.

The general program of the Convention reflected boldly the many research activities of the composing disciplines of the Gerontologic Organization and the delegates represented a hard working group of men and women who have not wasted any time out of the limited number of days of the Convention at their disposal and worked hard from the beginning of the Convention to its end.

In conclusion we wish to thank Dr. Huntington Williams, Commissioner of Health for the City of Baltimore for the very friendly gesture extended to the Committee and the Convention by dedicating the Health Bulletin that is published monthly by the Health Department, to the Convention. This bulletin was issued in the middle of September in time for the Convention and contained greetings and the full program and proceedings as outlined for the three day period of the Convention.

We likewise, wish to express our thanks to Mrs. Conrad Acton and Mrs. William D. Lynn for their cooperation on Thursday evening as hostesses for the reception at the Medical Chirurgical Building.

We further extend our thanks to the Convention Bureau of the City of Baltimore for their share in the work to help make the Convention a success. And to the press for their cooperation.

Thanks to the General Committee who have labored long and hard in the preparatory work for the Convention and as hosts to the delegates during the Convention.

Respectfully submitted,

HERMAN SEIDEL, M.D., *Chairman*
WALTER A. ANDERSON, M.D.
D. DELMAS CAPLES, M.D.
THURSTON HARRISON, M.D.
LAURISTON L. KEOWN, M.D.
LOUIS KRAUSE, M.D.
NATHAN E. NEEDLE, M.D.
A. AUSTIN PEARRE, M.D.
(1955 Committee)

GERIATRICS COMMITTEE (1956)

Mr. President and Members of the House of Delegates:

The first meeting of this Committee on March 15, 1956 was a joint meeting of the Geriatrics Committees of the Baltimore City Medical Society and the Medical and Chirurgical Faculty.

In the absence of the Chairman, who was unable to attend because of illness, the Co-Chairman presided. The discussion centered on the redraft of a resolution to expand the Geriatrics Committee of the Medical and Chirurgical Faculty. The possible participation of the present Baltimore City Committee was explored and the question was referred to the Baltimore City Medical Society for consideration.

Respectfully submitted,
V. L. Ellicott, M.D., *Chairman*
Herman Seidel, M.D., *Co-Chairman*
Albert L. Anderson, M.D.
Louis Z. Dalmau, M.D.
Charles R. Foutz, M.D.
W. Grafton Hersperger, M.D.
Benjamin Kader, M.D.
George J. Kreis, Jr., M.D.
Thomas F. Lusby, M.D.
George S. Mirick, M.D.
Norman E. Sartorius, Sr., M.D.
(1956 Committee)

COMMITTEE ON INDUSTRIAL HEALTH

Mr. President and Members of the House of Delegates:

This Committee held 2 meetings in the course of the year and also an additional meeting to recommend a nominee from Maryland for the President's Award. As in the past, the Committee has served chiefly as a clearing house for information relative to Industrial Health and has received a number of inquiries. It has also on occasion tried to obtain jobs for physicians interested in Industrial Health. The members of the Committee will be glad to address County Medical Societies or other groups interested in receiving information on this subject, but in the course of the past year, no such requests have been received.

Respectfully submitted,
Nathan B. Herman, M.D., *Chairman*
Thurston R. Adams, M.D.
John William Ashworth, M.D.
Robert F. Chenowith, M.D.
C. Reid Edwards, M.D.
William H. Fisher, Jr., M.D.
Walter E. Fleischer, M.D.
Hugh C. F. Gill, M.D.
Donald B. Grove, M.D.
F. Ford Loker, M.D.
William A. Pillsbury, Jr., M.D.
Perry F. Prather, M.D.
Charles A. Reifschneider, M.D.
Conrad L. Richter, M.D.
Benjamin H. Rutledge, M.D.
Leroy W. Saunders, M.D.
Huntington Williams, M.D.

LEGISLATIVE COMMITTEE

Mr. President and Members of the House of Delegates:

Since it was a short session of the 1956 General Assembly, a limited number of Bills were allowed for consideration. Our Legislative Agent, Mr. Walter N. Kirkman, reviewed 251 Bills and Resolutions to make sure there was no medical implication in them. Of this number, only two, House Bill No. 15 and House Bill No. 16, were of interest to the Medical and Chirurgical Faculty.

House Bill No. 15 provided that the fee for examination by the Board of Medical Examiners of Maryland would be changed from $20.00 to $35.00. This Bill was passed without incident in both Houses.

House Bill No. 16 provided certain changes in the causes for which the Board of Medical Examiners may revoke medical licenses. These changes include addiction to narcotics and insanity. This Bill also contained a provision that the decision of the Circuit Court concerning the revocation of licenses would be subject to review by the Court of Appeals. With some minor difficulty this Bill was gotten through the lower House and was gotten out of the Rules Committee to the Judiciary Committee of the Senate. The members of this Committee felt that from a legal standpoint such cases should not go to the Court of Appeals, and they therefore gave the Bill an unfavorable report. It was not reported out of Committee and therefore died in Committee.

The Legislative Committee feels that the Medical and Chirurgical Faculty owes a debt of gratitude to Mr. Kirkman for his good services in carefully scrutinizing the activities of the Legislature, therefore looking to the best interests of the people of Maryland along medical lines.

Federal Legislation. In regard to Federal legislation on medical matters, the Committee was in constant consultation with the Secretary of the Medical and Chirurgical Faculty and the Director. Telegrams were sent to the proper authorities in Washington on certain pieces of legislation. No direct action other than this was necessary on Federal legislation.

A Regional Legislative Conference in reference to legislation was held in New York, and the Medical and Chirurgical Faculty was represented by Dr. M. B. Davis, Mr. Kirkman, Mr. Marden and the writer.

Respectfully submitted,
Karl F. Mech, M.D., *Chairman*
Frederic V. Beitler, M.D.
Henry A. Briele, M.D.
Melvin B. Davis, M.D.
George O. Eaton, M.D.
William L. Garlick, M.D.
Raymond F. Helfrich, M.D.
William T. Layman, M.D.
Louis G. Llewelyn, M.D.
John Mace, Jr., M.D.
S. Edwin Muller, M.D.

Each Component Society is represented by the incumbent President, Secretary and Treasurer and also the Chairman of the Legislative Committee of the Baltimore City Medical Society, Charles R. Goldsborough.

MARYLAND MEDICAL SERVICE INCORPORATED

Mr. President and Members of the House of Delegates:

We have just completed our fifth full year of operations, and it is my pleasure to report to you on the progress of Maryland's Blue Shield Plan during 1955.

Last year we experienced a substantial gain in membership in our standard program, from 162,153 to 228,466 subscribers, a net gain of 66,313, or 41%. If we include the subscribers covered under the special surgical program for Bethlehem Steel, the total membership at the end of 1955 was 344,409. This membership represents 37% of the total Blue Cross membership at the year-end.

This has been an excellent record of enrollment growth. The present enrollment under the standard plan includes 181,700 group subscribers, 41,000 who pay direct, and nearly 6,000 subscribers who have enrolled under our non-group membership program which was started in September of 1954.

We are especially pleased with the non-group results. Though this type of membership is still small numerically in relation to group enrollment, growth has been steady, and this program meets a definite need in the community.

It is fair to say, I believe, that part of our membership growth in 1955 stems from our local educational campaign, together with the advertising by Blue Shield Plans jointly in national media. Our Blue Shield program is relatively new, so our educational program has been very effective in getting information to the public about how Blue Shield can help in meeting medical expenses.

Financial growth has accompanied membership growth. Our total assets exceeded the million dollar mark in 1955, and stood at $1,228,619 at the year-end. Our total income from subscribers in 1955 was $2,882,572, and out of this we paid $2,304,506, or 79.8% in benefits to subscribers. After operating expenses, which were 10.8% of our total income, we put aside 9.4% in reserves, somewhat more than we did in 1954.

It would be natural for you to ask why Blue Shield should pay out only 80% of its income in benefits while Blue Cross paid out nearly 93% in 1955. There are several reasons. For one thing, Blue Cross rates are going up early in 1956 simply because they paid out such a high percentage in 1955. Also, it is important to remember that Blue Shield is a much younger plan, we have not as yet been able to build our reserves to necessary levels, and we are still experiencing a high rate of new enrollments with attendant limitations on certain benefits (obstetrics and tonsils and adenoids, for example). Once our new membership growth slows down, we can expect that an increasing percentage of income will be paid out for benefits.

Last year we provided benefits under our standard program to 23,305 subscribers, as compared with 16,640 receiving benefits in the previous year. Of the hospitalized cases, 57% included surgery, 30% were medical admissions, and the remaining 13% were obstetrical cases. Twenty-eight per cent of the subscribers also received benefits for anesthesia and for consultations.

In mid-1955 our Medical Director and administrative staff began work on a revision of our standard Blue Shield Plan. Our experience with both subscribers and physicians since September 1, 1952, when the present fee schedule and benefit provisions went into effect, convinced us that there was a need to make certain adjustments in the program. We wanted to eliminate inconsistencies and inequities in the fee schedules, and we felt it desirable to add certain new areas of benefits. After several months of study and discussion, and consultation with committees of physicians in the various specialties, we developed the revised program which will go into effect on May 1, 1956. Subscription rates will be increased slightly to cover the additional costs of the new benefits. We are convinced that the revised fee schedule and benefit provisions represent an important improvement in our Blue Shield program—for subscribers and doctors alike.

In the immediate future we will work on a second Blue Shield Plan, with a higher benefit schedule and higher income limits, to be offered to groups that desire broader protection than we can now provide. Nationally, many Blue Shield Plans are now offering such higher level programs, in recognition of the generally high wage and salary levels in effect. There is no question but that our present $4,000 family income limit under which full coverage is provided is low in relation to family income levels in this area. We expect to present this higher benefit program to our Participating Physicians for their consideration within the next few months.

In closing, let me comment briefly about Blue Shield nationally. The 77 Blue Shield Plans, the majority of them partial-service programs like Maryland Medical Service, had a total membership of over 34 million at the end of 1955, gaining some three million subscribers during the year. Together these Plans paid out some $350 million in benefits for over seven million separate physicians' services. And in the areas served by Blue Shield Plans, there are 122,000 participating physicians, roughly 89% of all physicians in these areas. This is certainly a splendid record of cooperation by the medical profession.

I want to extend my sincere thanks to the members of the Board of Trustees, to the Participating Physicians in the State, and to our Blue Shield administrative staff, for their splendid cooperative effort in making 1955 such a notable year of progress for Maryland Blue Shield. I am sure that we will establish new records of growth in 1956 and in the years ahead.

Respectfully submitted,
HENRY F. ULLRICH, M.D., *President*

MARYLAND MEDICAL SERVICE INCORPORATED AND MARYLAND HOSPITAL SERVICE INCORPORATED, FIRST ANNUAL REPORT (PATHOLOGY, RADIOLOGY, ANESTHESIOLOGY)*

Mr. President and Members of the House of Delegates:

The Committee report of which the resolution is a part makes reference to a number of specialty services or groups. We assume from a reading of the full report that the matters on which we are requested to comment pertain only to the provision of Blue Cross and/or Blue Shield benefits for pathology, radiology, and anesthesiology.

Effective May 1, 1956, revisions are being made in the benefit provisions for both the standard Blue Cross and Blue Shield

* "Committee to Confer with Blue Cross and Blue Shield in Regard to Radiological Section and Maryland Radiological Section Resolution of April 26, 1954."

Plans. Set forth below is a summary of the benefits to be provided on and after that date for pathology, radiology, and anesthesiology.

PATHOLOGY

Standard Blue Cross

Pathological services in connection with *in-patient* care are covered in full under the following certificate provisions:

"Laboratory examinations necessary for the diagnosis and treatment of the condition for which hospital care is required."

Out-patient benefits are limited to emergency care following accidental injury (initial visit only) and for minor surgical procedures required for treatment and not solely for diagnosis; pathological services to the extent used in such cases are covered.

Standard Blue Shield

Laboratory and pathological specimen examinations are specifically excluded under the certificate provisions.

RADIOLOGY

Standard Blue Cross

Diagnostic x-ray services in connection with in-patient care** are covered in full under the following certificate provisions:

"X-ray examinations necessary for the diagnosis and treatment of the conditions for which hospital care is required."

Out-patient benefits are limited to emergency care following accidental injury (initial visit only) and for minor surgical procedures required for treatment and not solely for diagnosis; diagnostic x-ray services to the extent used in such cases are covered.

X-ray therapy services are specifically excluded under the certificate.

Standard Blue Shield

Diagnostic x-ray services are covered when ". . . rendered by a physician outside of a hospital for fractures and dislocations within 72 hours of an accident. The maximum allowance for such services related to any one accident or injury shall be $15.00." Benefits are in accordance with a fee schedule for services within the maximum allowance.

X-ray therapy is covered under the following provision: ". . . benefits for radiation therapy services when administered by a physician for the treatment of neoplasms, adenoids, and disorders of the female genital system by use of roentgen rays or by the application or implantation of radium or radon." These services are provided in accordance with a fee schedule, to a maximum of $150 for deep x-ray, either in or out of the hospital. No benefits are provided for radium rental or radon purchase.

** Admissions primarily for diagnostic x-ray, laboratory, or electrocardiographic examinations, or other diagnostic studies, are excluded.

ANESTHESIOLOGY

Standard Blue Cross

Anesthesia services in connection with *in-patient* care are covered under the following certificate provision:

"Anesthesia, when administered by an employee of the hospital (if such anesthesia service is not available at the hospital selected, the subscriber may receive a reimbursement of not to exceed $10.00 toward the charges of a private anesthetist)."

Out-patient benefits are limited to emergency care following accidental injury (initial visit only) and for minor surgical procedures required for treatment and not solely for diagnosis; anesthesia services to the extent used in such care are covered.

Standard Blue Shield

Anesthesia benefits in connection with hospital care are provided in accordance with a fee schedule related to the applicable surgical fee, to a maximum of $40.00.

Both the Blue Cross and Blue Shield certificates are mutually exclusive, i.e., each certificate carries a provision that it will not provide benefits for any services which are provided under the other program. For example, if the patient has both Blue Cross and Blue Shield coverage and is hospitalized where he receives the services of a private anesthetist not employed by the hospital, benefits are provided under Blue Shield only. If the anesthesia service is provided by an employee of the hospital, benefits are provided under Blue Cross only.

Respectfully submitted,
MR. R. H. DABNEY, *Director*

MATERNAL AND CHILD WELFARE COMMITTEE (1955)

Mr. President and Members of the House of Delegates:

No report, as the Chairman is abroad and Dr. J. Morris Reese has included in his report some of the facts brought out by the Committee during Dr. Eastman's Chairmanship.

PEDIATRIC SECTION

J. EDMUND BRADLEY, M.D., *Vice-Chairman*—1955

For some years the Committee has been concerned about the rising infant mortality rate in Maryland. For the State as a whole, this rate improved somewhat in the last two years, but the rate for Baltimore City has continued to rise—30.2 in 1953 and 31.9 in 1954. (New York City rate for 1953 was 20.3)

	City	State	National
1950	27.2	28.2	29.2
1951	29.8	28.9	28.4
1952	27.9	29.4	28.4
1953	30.2	27.0	27.8
1954	31.9	26.9	—

Contributory factors seem to be: a) overcrowded hospital facilities. b) insufficient nursing help, c) infection with resistant strains of organisms, and d) shortened hospital stay. It is the unanimous opinion of the Committee that every effort should be made to rectify the situation by improving the physical facilities of the hospitals, nursing and medical care, educational programs for mothers, and follow-up care of the infants.

After careful study the Committee has concluded that: 1) The practice of studying premature deaths by means of questionnaires to individual physicians should be discontinued. 2) Infant deaths under 7–10 days should be reviewed by the Committee and statistics compiled by hospital. It is hoped that this would stimulate interest of the hospital in its own rate and result in improvement.

Final Figures for 1954

	Ctiy	Counties	Total	% Death
Live births	23,523	43,992	67,445	
Weighed 2500 grams or less	2,378	3,158	5,536	
Infant deaths	751	1,065	1,816	100%
Neonatal deaths	548	753	1,301	71%
Deaths under 7 days	483	654	1,137	62%
Deaths in prematures	361	452	813	44%

From the above table it is seen that 62% of infant deaths occur in the first seven days, 44% occurring in premature infants. If the Committee would concentrate on all deaths in the first 7–10 days, the large majority of premature deaths would be included.

MATERNAL SECTION

J. EDMUND BRADLEY, M.D., *Vice Chairman*—1955

For this new study the approval and endorsement of the Material Section of this Committee, the Baltimore City Medical Society, the Medical and Chirurgical Faculty, and the Hospital Association would be needed. A pilot study including about three hospitals in the city and three in the counties is planned for 1956.

The Committee, in addition, has been interested in the facilities and cost of care for premature infants. It was noted with satisfaction that the Maryland Blue Cross coverage will be extended in March 1956, to cover prematures as well as other newborn infants requiring hospitalization after the mother is discharged.

A request was sent to the State Health Department laboratory requesting typing determinations of E. Coli involving outbreaks of diarrhea in nurseries.

A statement of the relationship between high oxygen concentration and retrolental fibroplasia was published in the State Medical Journal. Copies were also sent to hospitals.

The "Guide to the Care of Newborn Infants" was brought up to date and distributed to hospitals.

Many other subjects pertaining to child welfare in the State are considered.

Respectfully submitted,
NICHOLSON J. EASTMAN, M.D., *Chairman*
J. EDMUND BRADLEY, M.D., *Vice-Chairman*
GEORGE W. ANDERSON, M.D.
ARTHUR BAPTISTI, JR., M.D.
JOHN MCF. BERGLAND, M.D.
ANNIE M. BESTEBREURTJE, M.D.
HARRY D. BOWMAN, M.D.
THOMAS A. CHRISTENSEN, M.D.
STUART CHRISTHILF, JR., M.D.
GEORGE H. DAVIS, M.D.
D. MCCLELLAND DIXON, M.D.
H. W. ELIASON, M.D.
ABRAHAM H. FINKELSTEIN, M.D.
S. BUTLER GRIMES, M.D.
WILSON GRUBB, M.D.
I. RIVERS HANSON, M.D.
JANET B. HARDY, M.D.
PAUL HARPER, M.D.
JOHN S. HAUGHT, M.D.
W. ROYCE HODGES, JR., M.D.
D. FRANK KALTREIDER, M.D.
W. KENNETH MANSFIELD, M.D.
W. C. MORGAN, M.D.
ALBERT M. POWELL, M.D.
J. MORRIS REESE, M.D.
JOHN EDWARD SAVAGE, M.D.
ALEXANDER J. SCHAFFER, M.D.
JEAN R. STIFLER, M.D.
WILLIAM C. STIFLER, JR., M.D.
BYRON D. WHITE, M.D.
JOHN WHITRIDGE, JR., M.D.
(1955 Committee)

MATERNAL AND CHILD WELFARE COMMITTEE (1956)

Mr. President and Members of the House of Delegates:

OBSTETRICAL SECTION

During the year 1955, the deaths from maternal causes was 4.3 per ten thousand live births which is the lowest figure ever attained in the State of Maryland. Unfortunately, ten of the seventeen deaths due to maternal causes, or 59%, were judged preventable on the part of the Physicians or on the part of the patients (8 preventable by Physicians—2 preventable by patients). Three deaths, or 17% only, were judged non-preventable. Of the other four deaths, on two there was no information submitted and in two cases the cause of death was indeterminable. There were five deaths in pregnant women due to non-maternal causes. So, while we have the lowest maternal death rate ever reported, we have not reached the goal for which we have been striving, namely: that of no maternal deaths.

The Physicians of the Counties of Maryland, however, are to be congratulated on their work both from a prenatal standpoint and from the standpoint of their care and interest during labor and puerperium.

They are further to be congratulated for having accom-

plished what previous committees have so frequently requested, namely:—that of bringing "Blood Banks" and blood transfusions facilities up to a higher standard. According to information at hand, it has been three years since we have had a maternal death due to lack of available blood transfusions.

Maternal Mortality Rates—Counties of Maryland—1955

	White		Colored		Total	
	No.	Rate*	No.	Rate	No.	Rate
(1) Deaths						
Maternal Causes	10	2.9	7	12.7	17	4.3
Non-maternal Causes	5	1.4	0	—	5	1.3
Total Deaths Associated with Pregnancy					22	5.5

	No. of Deaths		Per cent
	White	Colored	
(2) Preventability (maternal causes only)			
Preventable—physician		8	59%
Preventable—patient		2	
		10	
Indeterminate		2	12%
Non-preventable		3	17%
No information submitted		2	12%
(3) Maternal Causes of Death			
Hemorrhage		6	
Postpartum	2		
Ruptured ectopic pregnancy	1		
Ruptured uterus	1		
Perforated uterus, criminal abortion	1		
Abruptio	1		
Infection			
Peritonitis, ruptured		3	
Ovarian abscess	1		
Bacteremia	1		
Infected criminal abortion	1		
Embolism		6	
Pulmonary	3		
Amniotic fluid	2		
Air embolism	1		
Miscellaneous		2	
Acute pulmonary edema after cesarean section	1		
Cerebral hemorrhage in puerperium	1		
(4) Deaths Associated with Pregnancy		5	
Rheumatic heart disease with cardiac failure	2		
Infectious hepatitis	2		
Acute hepatic insufficiency	1		

* Per 10,000 live births.

The Committee makes the request for more strenuous efforts to obtain autopsies of these patients and to obtain better performed autopsies.

Your Committee is somewhat disturbed relative to several cases which were handled by midwives. Under the Laws of Maryland, "All cases authorized for delivery by a midwife must be certified as suitable for a midwife delivery by a private physician or physician in County Health Department prenatal clinics. A midwife may practice midwifery in cases of normal labor in which there is an uncomplicated head presentation." Your Committee suggests that some method of knowledge of these regulations be transmitted to the practicing midwives in the several Counties emphasizing this law, and that the physicians in the several Counties be further circularized and again reminded of this regulation.

Your Committee is attempting a study of all neo-natal deaths in term babies delivered by Caesarian Section in the Counties. This is a subject of great interest both to Obstetricians and Pediatricians and we hope, within the not too distant future, to have at least a preliminary report.

This Committee wishes to thank all of the Physicians who so promptly and completely completed the questionnaires which they received. By their efforts, the studies of the Committees and their findings were greatly expedited.

Respectfully submitted,

J. Morris Reese, M.D., *Chairman*
Paul Harper, M.D., *Vice-Chairman*
George W. Anderson, M.D.
Annie M. Bestebreurtje, M.D.
Harry D. Bowman, M.D.
Stuart Christhilf, Jr., M.D.
Irvin M. Cushner, M.D.
George H. Davis, M.D.
D. McClelland Dixon, M.D.
H. W. Eliason, M.D.
Abraham H. Finkelstein, M.D.
S. Butler Grimes, M.D.
Russell L. Guest, M.D.
Janet B. Hardy, M.D.
Arthur L. Haskins, M.D.
John S. Haught, M.D.
W. Royce Hodges, Jr., M.D.
D. Frank Kaltreider, M.D.
W. Kenneth Mansfield, M.D.
Hugh B. McNally, M.D.
W. C. Morgan, M.D.
Richard B. Norment, III, M.D.
John E. Savage, M.D.
Stedman W. Smith, M.D.
B. P. Warren, M.D.
Byron D. White, M.D.
John Whitridge, Jr., M.D.
(1956 Committee)

MARYLAND ADVISORY COMMITTEE TO SELECTIVE SERVICE

Mr. President and Members of the House of Delegates:

This Committee has been functioning routinely along precedence established under the Chairmanship of Dr. R.

Walter Graham. No new change in policy has been promulgated by the Selective Service System in regard to the doctor draft since I assumed the Chairmanship of this Committee.

No changes in the functioning of this Committee are to be proposed at this time.

Respectfully submitted,
JOHN W. PARSONS, M.D., *Chairman*

JOINT COMMITTEE WITH THE BAR ASSOCIATIONS OF MEDICOLEGAL PROBLEMS

Mr. President and Members of the House of Delegates:

January–March, 1956—RUSSELL S. FISHER, M.D., *Chairman*

(Includes 1955 report—LOUIS KRAUSE, M.D., *Chairman*)

The medical members of the Committee met with the legal members of the Committee on February 16, 1956. The work of the Committee during the last few years was reviewed.

The Symposia Management Subcommittee reported on a series of symposia, including, during 1955, presentations under the following titles:

Trauma or Heart Disease
Post-Concussion Syndrome or Malingering
Mental Competency of Patients and Clients

The Subcommittee on Inter-Professional Relations reported they had had no occasion to meet since there had been no formal complaints made by members of one profession against the other during the entire life of the Committee.

The Subcommittee on Court Procedure had nothing further to report on the plan for use of "court appointed experts."

The Symposia Management Subcommittee met on March 8, 1956 and plans were made for a symposium early in May on the subject "The Legal Aspects of Compulsory Medical Care." The final title and participants have not as yet been selected.

The medical members of the Joint Committee for 1956, with their respective Subcommittees are as follows:

Symposia Management:

DR. CONRAD ACTON
DR. MELVIN B. DAVIS
DR. JOHN E. MILLER
DR. RICHARD SHACKELFORD

Inter-Professional Relations:

DR. JOHN M. DENNIS
DR. MANFRED S. GUTTMACHER
DR. KENNEDY WALLER

Court Procedures:

DR. HOWARD F. KINNAMON
DR. HENRY F. ULLRICH
DR. SAMUEL R. WELLS

Respectfully submitted,
LOUIS KRAUSE, M.D., *Chairman*
CONRAD ACTON, M.D.
LEO BRADY, M.D.
RUSSELL S. FISHER, M.D.
WETHERBEE FORT, M.D.
MANFRED S. GUTTMACHER, M.D.
CHARLES A. REIFSCHNEIDER, M.D.
I. RIDGEWAY TRIMBLE, M.D.
HENRY F. ULLRICH, M.D.
WALTER D. WISE, M.D.
(1955 Committee)

RUSSELL S. FISHER, M.D., *Chairman*
CONRAD ACTON, M.D.
MELVIN B. DAVIS, M.D.
JOHN M. DENNIS, M.D.
MANFRED S. GUTTMACHER, M.D.
HOWARD F. KINNAMON, M.D.
JOHN E. MILLER, M.D.
RICHARD T. SHACKELFORD, M.D.
HENRY F. ULLRICH, M.D.
W. KENNEDY WALLER, M.D.
SAMUEL R. WELLS, M.D.
(1956 Committee)

MEMOIR COMMITTEE*

Mr. President and Members of the House of Delegates:

During the past year 31 members of the Faculty have passed on. Attempt has been made to recall the salient life events and to epitomize the professional achievements of each one in the MARYLAND STATE MEDICAL JOURNAL. This Committee's effort has been greatly enriched by the kindly offices of twenty contributing authors, selected at the request of the next of kin to whom their words of appreciation have proved a great comfort in a grievous trial.

As a Society our losses have been heavy indeed, including our most loved and respected senior member after a full rich life that will remain as a blessed memory. A career brilliant in research has been interrupted. Lives crowded with intense activity have dropped into sudden silence. The voices of kindly understanding advisors are abruptly stilled. There are even those whose considered judgment of their own lives was bleak and hopeless failure.

Confronted by our collective inadequacy against the mountain of human misery and the tragic brevity of the most brilliant effort, we go in sorrow to the grave, saying with Cecil Rhodes, "So much to do; so little done!" There is sorrow but not despair, except for minds whose intellectual bias is so extreme as to admit neither prophesy nor history, such as the late (but not the only) sage of Baltimore, to whom immortality of the soul "seemed wholly incredible and preposterous." By ourselves and on our own strength it certainly would be, but for a perennial blooming of new energies to finish better than we can now know the work that these in fullness or frustration have had to lay down. In new young lives, dedicated as wholly as these who have gone on their

* Report given during the General Scientific Meeting, Thursday morning, May 3, 1956.

way, we find an earnest of an everlasting power that has plans we may not know, bringing new lights to old problems and fulfillment to faded dreams in due time. We may not know the future but we hold its key, which is the highest attribute of man, namely, the faculty of feeling an obligation to give his life in doing his best, with a sure instinct that here we come closest to the Eternal, the ultimate good.

Baltimore City

Abercrombie, Anna S. ..... October 31, 1955
Balfour, Charles E. ..... January 19, 1956
Bordley, James, Jr. ..... January 7, 1956
Bossyns, Albert J. ..... October 20, 1955
Boyd, Kenneth B. ..... October 23, 1955
Chatard, J. Albert ..... January 27, 1956
Clapp, Clyde Alvin ..... April 9, 1955
Constadt, Hans W. ..... July 2, 1955
Crowe, Samuel J. ..... November 13, 1955
Ephriam, Meyer ..... December 24, 1955
Friedenwald, Jonas S. ..... November 5, 1955
Legge, Kenneth D. ..... January 22, 1956
Lilienthal, Joseph L., Jr. ..... November 19, 1955
Shipley, Arthur M. ..... October 16, 1955
Solomon, Milton L. ..... February 14, 1956
Sprunt, Thomas P. ..... April 26, 1955
Stewart, George A. ..... April 23, 1955
Teagarden, Ersie V. ..... September 5, 1955
Traband, John H., Jr. ..... April 16, 1955
Vest, Cecil Woods ..... July 3, 1955
Vozel, Luther F. ..... August 10, 1955
Wilson, Marion E. ..... January 9, 1956
Zepp, Herbert E. ..... December 2, 1955

Baltimore County

Carmine, Walter M. ..... October 13, 1955
Newell, H. Whitman ..... August 18, 1955
Nichols, Elijah E. ..... April 6, 1956

Dorchester County

Frazier, L. G. ..... July 3, 1955
Meade, James W., Jr. ..... March 18, 1956

Frederick County

Conley, Charles H. ..... March 20, 1956

Talbot County

Mason, Frank E. ..... November 20, 1955

Washington County

Miller, Victor D. ..... September 21, 1955
Smith, W. Hamilton ..... November 7, 1955

Respectfully submitted,
A. S. Chalfant, M.D., *Chairman*
John F. Hogan, M.D.
Robert H. Riley, M.D.

MENTAL HYGIENE COMMITTEE (1955)

Mr. President and Members of the House of Delegates:

The main activity of this Committee for the past year involved its Chairman's attending the second annual conference of "Mental Health Representatives of State Medical Associations," sponsored by the Council on Mental Health of the American Medical Association, in Chicago on November 18 and 19, 1955. A brief summary covering his conference was forwarded to Dr. Everett S. Diggs, Secretary, on December 7, 1955.

In preparation for that meeting a preliminary statement covering the attitude of this Committee was forwarded to the American Medical Association's Committee after having been submitted to the Secretary and to the other members of the Committee. Several inquiries on specific topics were referred by the Secretary of the Faculty. Appropriate answers were made.

The Chairman has continued to hold his office in mind as he has attended various meetings of psychiatric organizations, with the intention of reporting back any information or attitudes which it was felt should be brought to your attention or that of the House of Delegates. I am happy to say that no situation of sufficient importance to necessitate this action has emerged during 1955, though it is felt that certain attitudes toward the mental hygiene problem are under way in the State of Maryland which are likely to crystallize to the point that they will merit attention by future Chairmen of this Committee.

The entire Mental Hygiene Committee stand ready to assist you or the members of the new Committee in every possible way.

Respectfully submitted,
Harry M. Murdock, M.D., *Chairman*
Dexter M. Bullard, M.D.
Robert E. Gardner, M.D.
Kenneth B. Jones, M.D.
Wendell S. Muncie, M.D.
H. Whitman Newell, M.D.
Irving J. Spear, M.D.
Ralph P. Truitt, M.D.
(1955 Committee)

MENTAL HYGIENE COMMITTEE (1956)

Mr. President and Members of the House of Delegates:

If report is submitted, will be distributed to Delegates.

Respectfully submitted,
Jacob Ellis Finesinger, M.D., *Chairman*
Jerome D. Frank, M.D.
Manfred S. Guttmacher, M.D.
Kenneth B. Jones, M.D.
William W. Magruder, M.D.
Clifton T. Perkins, M.D.
Kent E. Robinson, M.D.
Irving J. Taylor, M.D.
Sarah S. Tower, M.D.

ISADORE TUERK, M.D.
JAMES S. WHEDBEE, JR., M.D.
(1956 Committee)

COMMITTEE ON NATIONAL EMERGENCY MEDICAL SERVICE

Mr. President and Members of the House of Delegates:

Dr. Robert H. Riley, my predecessor, has asked me to respond to your letter of February 23, 1956 relative to the Faculty's Committee on National Emergency Medical Service of which he was Chairman until December 31, 1955.

From March 11, 1955, the date of the last previous report, until December 31, 1955 the National Emergency Medical Service Committee was not called into formal session. However, during this period, all medical Civil Defense activity in the State was conducted along the lines set forth and policies enunciated by the committee at a former gathering held in conjunction with the full membership of the Medical Civil Defense Advisory Council.

Recommendations: None

Respectfully submitted,
ROBERT H. RILEY, M.D., *Chairman*
J. ALBERT CHATARD, M.D.
ALAN M. CHESNEY, M.D.
EVERETT S. DIGGS, M.D.
C. REID EDWARDS, M.D.
CHARLES W. MAXSON, M.D.
PERRY F. PRATHER, M.D.
GEORGE H. YEAGER, M.D.
MR. WALTER N. KIRKMAN
(1955 Committee)

COMMITTEE ON NATIONAL EMERGENCY MEDICAL SERVICE

Mr. President and Members of the House of Delegates:

One meeting has been held by this Committee and the readiness of physicians for emergency disaster duties were deliberated, and a plan was considered for making their services more readily accessible. Recommendations: None.

Respectfully submitted,
I. RIDGEWAY TRIMBLE, M.D., *Chairman*
PERRY F. PRATHER, M.D., *Co-Chairman*
ALAN M. CHESNEY, M.D.
J. SHELDON EASTLAND, M.D.
PALMER H. FUTCHER, M.D.
ROBERT C. KIMBERLY, M.D.
CHARLES W. MAXSON, M.D.
HUNTINGTON WILLIAMS, M.D.
FRANK D. WORTHINGTON, M.D.
(1956 Committee)

NEW BUILDING COMMITTEE

Mr. President and Members of the House of Delegates:

The Building Fund Committee is still functioning but definite progress cannot be reported, other than that the Building Fund is slowly increasing and we have now about $97,000 in the savings bank.

Very recently some interesting news, concerning a vast building plan in this neighborhood, has come to us and, while we are waiting for the Building Fund to be greatly increased, investigation of other possibilities than that of enlarging our present facilities, is being continued.

Respectfully submitted,
C. REID EDWARDS, M.D., *Chairman*
R. WALTER GRAHAM, JR., M.D., *Chairman, Subcommittee on Building Plans*

New Building Committee

Subcommittee on Finance

Mr. President and Members of the House of Delegates:

The Report from the Building Fund Committee this year is encouraging, but could be better. Since the assessment was placed on each member of the City and State Societies most members have accepted it as a matter of fact. In a number of cases there have been some laxity, but the Committee is hoping that this is the result of it being a new issue.

All assessments should have been paid by January 31, 1956. A few keep coming in each week even though they are delayed. If all members would have been paid up to date, it would swell our treasury of the Building Fund quite a bit.

Up to the present time we have in our treasury $92,892.17 that has actually been collected. Before we can go ahead and make definite arrangements regarding our building we must have at least fifty per cent of the actual amount necessary, which amounts to $160,000.00.

The Committee hopes that each Component Society will urge its members to pay up their assessments.

We wish to thank the members of the entire Society for their kind cooperation, and trust a better report will be forthcoming in the future.

Respectfully submitted,
ALBERT E. GOLDSTEIN, M.D., *Chairman*
JOHN W. PARSONS, M.D., *Treasurer*
JAMES G. ARNOLD, JR., M.D.
WILLIAM L. GARLICK, M.D.
HARRY C. HULL, M.D.
MARIUS P. JOHNSON, M.D.
RICHARD W. TELINDE, M.D.

New Building Committee

Subcommittee on Building Plans

Mr. President and Members of the House of Delegates:

In reply to your letter of February 23rd, there is no report to be submitted by the Building Committee.

Respectfully submitted,
R. WALTER GRAHAM, JR., M.D., *Chairman*

COMMITTEE FOR THE STUDY OF PELVIC CANCER

Mr. President and Members of the House of Delegates:

As of February 1, 1956, this Committee had included in its study eleven hundred and forty-five cases. These cases have been under treatment in the various hospitals of Baltimore

which are cooperating in the study. The cases have been reviewed and classified according to the delay period between the time of onset of symptoms and the time of correct diagnosis and adequate treatment. We have considered a time lapse of more than one month as delay. The cases have been classified as follows:

Patient Delay	494	43.1%
Physician Delay	95	8.3%
Physician and Patient Delay	73	6.4%
Institutional Delay	34	3.0%
Institutional and Patient Delay	24	2.1%
Institutional and Physician Delay	4	0.3%
Institutional, Physician and Patient Delay	2	0.2%
Inadequate or Improper Treatment*	11	1.0%
Delay due to Laboratory Error*	2	0.2%
No delay	376	32.8%
Asymptomatic Detected Cases	30	2.6%

Delay on the part of the physician was a factor in 15.2% of the cases; delay on the part of the hospital was a factor in 5.6%. There was delay on the part of the physician or hospital, or inadequate treatment in 21.5% of the cases.

It has been encouraging to note that cases are coming to treatment more promptly. In 1953, thirty per cent of the cases of cervical carcinoma included in the study showed no delay, with an additional nineteen per cent who were under treatment within two to three months after onset of symptoms. In 1955, there was no delay in thirty-nine per cent of the cases and an additional twenty per cent were under treatment within two to three months. There has also been a definite increase in the number of early cases under treatment. In 1953, forty per cent of the cervical cases were stage zero or stage one; in 1955, fifty-five per cent were stage zero or one.

Respectfully submitted,
RICHARD W. TELINDE, M.D., *Chairman*
FRANK K. MORRIS, M.D., *Vice-Chairman*
BEVERLEY C. COMPTON, M.D., *Secretary*
FERNENDEZ BLOEDORN, M.D.
THOMAS S. BOWYER, M.D.
C. BERNARD BRACK, M.D.
OSBORNE D. CHRISTENSEN, M.D.
ROBERT J. DICKSON, M.D.
WILLIAM K. DIEHL, M.D.
V. L. ELLICOTT, M.D.
GERALD A. GALVIN, M.D.
WILLIAM H. HANKS, M.D.
ARTHUR L. HASKINS, M.D.
WILLIAM ROYCE HODGES, JR., M.D.
HOWARD W. JONES, JR., M.D.
THEODORE KARDASH, M.D.
JOSEPH C. SHEEHAN, M.D.
A. ADLER SONDHEIMER, M.D.

PHYSIOTHERAPY COMMITTEE (1955)

Mr. President and Members of the House of Delegates:

The report on this Committee is negative.

* Classification added 1955.

Respectfully submitted,
H. ALVAN JONES, M.D., *Chairman*
HENRY BRIELE, M.D.
W. RICHARD FERGUSON, M.D.
MOSES GELLMAN, M.D.
JAMES P. MILLER, M.D.
(1955 Committee)

PHYSIOTHERAPY COMMITTEE (1956)

Mr. President and Members of the House of Delegates:

No meetings of the new Committe have been held since my appointment in January.

Respectfully submitted,
ROBERT C. ABRAMS, M.D., *Chairman*
MOSES GELLMAN, M.D.
WILLIAM P. HORTON, M.D.
HOWARD F. KINNAMON, M.D.
HARRY F. KLINEFELTER, JR., M.D.
JAMES P. MILLER, M.D.
(1956 Committee)

PROFESSIONAL CONDUCT COMMITTEE (1955)

Mr. President and Members of the House of Delegates:

This Committee held six formal meetings during the year 1955 (January 27, March 10, May 5, June 7, September 13 and December 20th). Fifty-six cases were heard involving complaints against 45 different doctors. Many letters and communications passed to establish the necessary data upon which decisions could be reached. The Attorney for the Medical and Chirurgical Faculty, Mr. G. C. A. Anderson, gave us very helpful advice on several occasions and was kind enough to meet with us at our final meeting December 20th.

The Committee proceeded to function throughout the year on the basis reported to the House of Delegates at our Annual Meeting in April, 1955, namely, that complaints requiring investigation must be submitted in writing stating clearly the specific grievance and must be signed by the complainant. We have not followed up rumors and reports. Some members feel that these should be investigated and it may be wise for the House of Delegates to decide whether the Faculty has the proper authority to follow through an investigation of rumors and reports.

The vast majority of our members were very co-operative and gave us excellent support in trying to resolve the problems presented, and we feel that in the majority of instances a grievance brought against a doctor by a patient grieves the doctor more than it grieves the patient. The Committee feels, after reviewing the increasing number of cases coming up for study, that the preponderance of problems arise from misunderstandings which would not and should not occur if the doctor and the patient sat down and talked over their differences. A word of explanation at the right time will save the doctor lots of worry.

While each case is, of course, an individual problem, your Committee was impressed that there was a trend for disagreements of complaints to fall into certain categories such as pressing for payment of fees by suit, a tired doctor losing his temper, or inadequate explanations to patients.

It was felt, too, by the Professional Conduct Committee that the information available as a result of the meetings of this Committee offers a wonderful source of practical material to be used in a course of medical ethics and that examples might be cited, omitting names and keeping the source date on an impersonal status, to illustrate to a young doctor or medical student what he should not do.

We repeat our conclusions of a year ago "Certainly recourse to a Professional Conduct Committee will be kept at a minimum if each member physician in all of his relationships, both with his patients and his professional colleagues, follows implicitly the ideal and the spirit of the Golden Rule."

Respectfully submitted,

A. Austin Pearre, M.D., *Chairman, Past President* (1950)
Walter D. Wise, M.D., *Past President* (1951)
Alan M. Chesney, M.D., *Past President* (1952)
Maurice C. Pincoffs, M.D., *Past President* (1953)
Bender B. Kneisley, M.D., *Past President* (1954)
Warfield M. Firor, M.D., *Chairman of Council* (1955 Committee)

PROFESSIONAL CONDUCT COMMITTEE (1956)

Mr. President and Members of the House of Delegates:

The Professional Conduct Committee has had one meeting since January 1st, 1956, this being on Thursday, February 23rd, 1956 at 4 P.M., the members present being Drs. Alan M. Chesney, Everett S. Diggs, Secretary (ex-officio), Mr. J. Marden IV, and the undersigned. (So far as I know there has been no ruling as to what constitutes a quorum.)

The minutes of the previous meeting were approved as submitted.

The Chairman suggested that the following procedure be utilized when a complaint is received:

The complaint should be acknowledged but, if it concerns a bill, the complainant be asked if he or she has taken it up with the doctor directly. This letter should make it clear to the complainant that the letter of complaint would be received by the doctor in question so that his side of the story can be evaluated. The Committee further discussed the utilization of the local society to handle complaints. It was pointed out that one of the physicians on the agenda today had expressed his dissatisfaction that his case was brought to the State Level without the opportunity of having it considered at the component level. The Committee feels that local handling of any complaint is preferable if the component society wishes to consider the complaint. No definite policy decision, however, was reached.

There was rather prolonged discussion of the types of cases that should be considered by the Professional Conduct Committee, the opinion being expressed by Dr. Chesney and the Chairman that the original intent of this Committee was for the consideration of settlement of difficulties between doctors and the laity and that such problems as the difficulties within professional staffs of hospitals predicated upon professional qualifications or lack of them should not come before this Committee nor should this Committee act upon the recent request from the State Board of Medical Examiners to take action in the case of alleged narcotic misuse.

The matter was referred to the Council, quoting Chapter 8, Section 8 of the newly modified Constitution and By-Laws, asking for clarification. The clarification consisted of having Chapter 8, Section 8 quoted back to the Chairman of the Professional Conduct Committee.

On the agenda there were 15 cases to be considered and in a session, lasting nearly 2½ hours, there were 12 complaints reviewed; 9 were acted upon, 3 were held so that further information might be obtained and the others for lack of time on this occasion.

It is noted that the Baltimore City Medical Society has done away with its Board of Censors and its duties have been assumed by the Executive Board of the City Society. Eleven counties have either a Committee or Board of Censors, eleven do not have such a Committee, and one county has not replied. Many counties state that they have had no complaints whatsoever.

Supplementary Report*

Since this report was given there has been another meeting of our Committee, where eleven more cases were considered and the results will be reported in the next Annual Report to this Body.

The following is quoted from the Council Meeting of April 24th:

"The Professional Conduct Committee requested a change in policy of handling the complaints being considered. One or two members of the Component Societies have indicated their dissatisfaction in not having the opportunity to consider complaints against their members at the local level. The A.M.A. policy suggested that complaints be handled at the local level but that there be a Committee available at State level where grievances may be brought if desired. As a majority of our complaints are concerning Baltimore City members, Baltimore City Medical Society is being asked if they would like to handle the grievances at City level. It is suggested that the same privilege be offered to the other Components."

Dr. Christensen moved that the grievances be transmitted to the Component Societies unless the Component Society requests State action. This was seconded and carried and will be presented to the House of Delegates."

As a result of the action of the Council THE PROFESSIONAL CONDUCT COMMITTEE RECOMMENDS THAT GRIEVANCES BE REFERRED TO THE COMPONENT SOCIETIES UNLESS THE COMPONENT SOCIETY REQUESTS ACTION BY THE PROFESSIONAL CONDUCT COMMITTEE OF THE MEDICAL AND CHIRURGICAL FACULTY.

Respectfully submitted,

Walter D. Wise, M.D. (*President in 1951*), *Chairman*
Alan M. Chesney, M.D. (*President in 1952*)
Maurice C. Pincoffs, M.D. (*President in 1953*)

* This committee met subsequently to mailing of Summary of Reports, and therefore this recommendation was not included in original report.

BENDER B. KNEISLEY, M.D. (*President in 1954*)
GEORGE H. YEAGER, M.D. (*President in 1955*)
WARFIELD M. FIROR, M.D. (*Chairman of Council in 1956*)
(1956 Committee)

COMMITTEE ON PUBLIC INSTRUCTION

Mr. President and Members of the House of Delegates:

During the year 1955 no formal meeting of the Committee on Public Instruction was held although Committee activities were still in effect and the members met or communicated informally with each other on various occasions such as Medical Society and Health Department meetings.

By far the most outstanding health event of the year was the inoculation program to prevent poliomyelitis. From the announcement on April 12 given at the University of Michigan affirming the value of the new Salk poliomyelitis vaccine and throughout the year the Committee made a strong effort to keep both physicians and lay public fully informed on the progress of the program. Approximately 396,597 polio inoculations were given throughout the State by physicians and public health agencies. The usual media of communication was used in disseminating this information—meetings and conferences, radio and television, the press and other publications.

The weekly radio and television program jointly sponsored with the Baltimore City Health Department were continued during the year. Radio and television stations also cooperated with the presentation of spot announcements and news releases. In particular radio and television stations were highly cooperative in publicizing the poliomyelitis inoculation program and National Diabetes Week in November.

Dr. Nels A. Nelson of the City Health Department staff continued to portray the family doctor in the "Keeping Well" radio drama series and Mr. Robert M. Keller served as Dr. John Worthington, the "physician" who is present at each program.

The weekly radio programs have been conducted since 1932. From 1932 to 1939 they were presented as five minute health talks. In 1939 it was decided to present the program as a fifteen minute health drama. This was continued until November 8, 1954 when the radio station notified the Committee that only ten minutes of time was available due to schedule rearrangements. Later on when the additional five minutes was again available it was recommended by the station that the program be limited and maintained as a ten minute drama and the program is now of that duration. The "Keeping Well" series is broadcast through the facilities of WFBR in Baltimore.

"Your Family Doctor" has been televised through the facilities of WMAR-TV in Baltimore since December 15, 1948 when the program was inaugurated by Dr. Charles W. Maxson, then President of the Medical and Chirurgical Faculty of Maryland, Dr. Huntington Williams, Commissioner of Health of Baltimore, Dr. Walter D. Wise, Chairman of the Council of the Faculty and Thomas D'Alesandro, Jr., Mayor of Baltimore City. This television program has been the prototype for numerous other health instruction programs developed throughout the country under either Medical Society or Health Department auspices or both. The Chairman of the Committee acted in a supervisory capacity over both radio and television programs. Both radio and television programs dealt with the many and varied health problems that are present in Baltimore City and throughout the State.

Assistance was also given to voluntary health agencies with their special campaigns during the year. The radio and television programs are in the public service category and the Committee gratefully acknowledges the stations' contributions as well as the assistance given by Medical Society members and other health workers in the production of these programs.

Other particular programs worthy of note dealing with public instruction in which Committee members participated were the state-wide Medical Care Program and especially in the publishing of a medical care *Formulary* for use by physicians in the Baltimore City Health Department's Medical Care Program, and the formation of the Maryland Public Health Association which had its inaugural meeting on December 8 in Annapolis. Throughout the year the Committee continued its work with the active support of State, County and City Health Departments. Through their work, with the active participation of Committee members, health instruction activities were carried on. Records of these activities may be found in the periodic Health Department reports, their regular publications and in their press releases.

Finally, it may be stated that Committee members have taken advantage of opportunities to present medical information to members of the medical profession and to the public at meetings, lectures and through the pages of the *Maryland State Medical Journal*.

Respectfully submitted,
HUNTINGTON WILLIAMS, M.D., *Chairman*
E. I. BAUMGARTNER, M.D.
RICHARD V. HAUVER, M.D.
PAGE C. JETT, M.D.
WILLIAM D. NOBLE, M.D.
ROBERT H. RILEY, M.D.
PETER P. RODMAN, M.D.
A. F. WHITSITT, M.D.
FRANK D. WORTHINGTON, M.D.
(1955 Committee)

COMMITTEE ON PUBLIC INSTRUCTION (1956)

Mr. President and Members of the House of Delegates:

The first meeting of this Committee was held Friday, February 17th at the Medical and Chirurgical Faculty Building, 1211 Cathedral Street. The Chairman, Dr. Harry M. Robinson, Jr., called the meeting to order at 5:00 P.M. Of the original committee, the Chairman, Dr. L. L. Keown, and Dr. Huntingdon Williams were present. Dr. H. Hanford Hopkins represented the Public Instruction Committee of the Baltimore City Medical Society, Dr. E. R. Shipley represented Dr. Stone, dean of the University of Maryland Medical School, and Dr. Carmichael Tillman represented Dr. Bard, dean of the Johns Hopkins School of Medicine. The Chairman suggested the necessity for the addition of new members to the

Committee so that at future meetings there would be a sufficient attendance to accomplish the necessary business. All of the men present agreed to serve on this Committee if appointed by the President.

Public Instruction by members of the Faculty at the present time consists of a weekly television show on current medical topics by the staff of the University of Maryland School of Medicine, and occasional participation by the Johns Hopkins School of Medicine on the Hopkins Science Review. A weekly television show is sponsored by the Baltimore City Medical Society and a weekly television is also sponsored by the Baltimore City Health Department and the Medical and Churgical Faculty of Maryland. In addition to this, the Baltimore City Health Department has a weekly radio show on station WFBR entitled "Keeping Well." The Commissioner of Health, Dr. Williams, submits a weekly statistical letter to the Mayor of Baltimore City. There is a large staff of public health nurses in both Baltimore City and the various counties of Maryland who are constantly disseminating medical information to the general public. These nurses also participate in maternal and child welfare clinics in the schools.

THE CHAIRMAN DISCUSSED THE QUESTION OF MISLEADING MEDICAL INFORMATION WHICH IS CONSTANTLY BEING PRESENTED IN THE VARIOUS NEWSPAPERS AND LAY JOURNALS. HE REQUESTED THAT THE MEMBERS OF THE COMMITTEE DISCUSS IDEAS FOR COMBATTING THIS. DR. HANFORD HOPKINS STATED THAT THE BALTIMORE CITY MEDICAL SOCIETY, THROUGH HIS COMMITTEE HAD CONSIDERED A PANEL OF PROMINENT PHYSICIANS WHO WERE AVAILABLE FOR THE PRESENTATION OF CURRENT MEDICAL TOPICS FOR LAY ORGANIZATIONS SUCH AS WOMEN'S ORGANIZATIONS, CHURCH GROUPS, AND OTHER LAY FUNCTIONS INCLUDING ROTARY CLUB GROUPS, ETC. HE SUGGESTED THAT WE CONSTRUCT A SIMILAR PANEL TO PRESENT TOPICS OF CURRENT MEDICAL INTEREST TO LAY GROUPS, AS PREVIOUSLY DESCRIBED, THROUGHOUT THE STATE OF MARYLAND. THIS PANEL WOULD BE CONSTRUCTED OF PROMINENT PHYSICIANS FROM OTHER PARTS OF THE STATE OF MARYLAND, AS WELL AS IN BALTIMORE CITY.

IT WAS SUGGESTED THAT A PROMINENT SPEAKER BE OBTAINED TO ADDRESS A JOINT MEETING OF THE MEMBERS OF THE MEDICAL FACULTY AND THE GENERAL PUBLIC. THIS MEETING SHOULD BE HELD IN SOME LARGE AUDITORIUM AT THE TIME OF THE ANNUAL MEETING.

DR. E. R. SHIPLEY SUGGESTED THAT A LIAISON BE FORMED BETWEEN THE UNIVERSITY OF MARYLAND, THE BALTIMORE CITY MEDICAL SOCIETY, THE STATE HEALTH DEPARTMENT, AND THE JOHNS HOPKINS SCHOOL OF MEDICINE SO THAT THERE WOULD BE NO CONFLICT BETWEEN THE VARIOUS MEDICAL PROGRAMS TO BE PRESENTED. IN THIS WAY, A LARGER VARIETY OF TOPICS COULD BE PRESENTED TO THE PUBLIC. IN THIS CONNECTION, THE CHAIRMAN SUGGESTED THAT DR. SHIPLEY ACT AS THE LIAISON OFFICER. THE CHAIRMAN SUGGESTED THAT A PROGRAM OF ALL OF THESE MEDICAL TOPICS FOR A PROLONGED PERIOD BE COMPILED AND PUBLISHED IN THE VARIOUS NEWSPAPERS AND RADIO AND TELEVISION JOURNALS.

THE COMMITTEE AGREES THAT WE SHOULD NOT SUPPORT ANY PARTICULAR DRIVES FOR MONEY BY VARIOUS MEDICAL GROUPS.

THE MEMBERSHIP OF THE COMMITTEE AGREED THAT PUBLICITY SHOULD BE GIVEN TO THE NATIONAL MEDICAL EDUCATION FOUNDATION DURING THE WEEK OF THIS CAMPAIGN. THIS IS TO BE DONE BY UTILIZATION OF THE VARIOUS TELEVISION PROGRAMS, THE NEWSPAPERS AND THE PRESS. THOSE RESPONSIBLE FOR THE VARIOUS TELEVISION AND RADIO PROGRAMS AGREED TO COOPERATE WITH DR. WILLIAM S. STONE WHO IS CHAIRMAN OF THIS CAMPAIGN FOR THE STATE OF MARYLAND.

THE COMMITTEE SUBMITS THIS REPORT FOR ACTION TO THE HOUSE OF DELEGATES AND AWAITS ITS DECISION BEFORE TAKING FURTHER ACTION.

Respectfully submitted,

HARRY M. ROBINSON, JR., M.D., *Chairman*
JAMES FEASTER, M.D.
H. HANFORD HOPKINS, M.D.
LAURISTON L. KEOWN, M.D.
WILLIAM T. LAYMAN, M.D.
E. T. LISANSKY, M.D.
RICHARD B. NORMENT, III, M.D.
HAROLD B. PLUMMER, M.D.
E. RODERICK SHIPLEY, M.D.
R. CARMICHAEL TILGHMAN, M.D.
THOMAS E. WHEELER, M.D.
HUNTINGTON WILLIAMS, M.D.
RICHARD J. WILLIAMS, M.D.
(1956 Committee)

RESOLUTIONS COMMITTEE

(Five members to be appointed annually by the President of the Medical and Chirurgical Faculty, who shall also designate the Chairman.)

Mr. President and Members of the House of Delegates:

The Resolutions Committee met in Baltimore on Saturday evening, April 21, 1956 at the home of the Secretary, Dr. Everett S. Diggs, with Doctors Cornbrooks, Davis, Farr and Campbell present.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

Resolution "A"

WHEREAS the Medical and Chirurgical Faculty of Maryland is made up of all the County and City Medical Societies

WHEREAS the officers and representatives elected by the Faculty are selected from the members of the local medical societies

WHEREAS under the present system the Nominating

Committee presents its slate of nominees to the House of Delegates one day before the election

WHEREAS in the past nomination has been tantamount to election or appointment

WHEREAS this system could lead to self-perpetuation

BE IT RESOLVED that the Nominating Committee shall present its slate of nominees early enough so that the Faculty can and shall send the report to the component societies at least two months before the Annual Meeting.

The Resolutions Committee recommends approval of this resolution with the addition of the following paragraph which has the approval of the sponsors.

"Be it resolved that Component Medical Societies be asked to submit any suggestions to the Nominating Committee by November 1st in order that such suggestions may be considered by the Committee."

Resolution "B"

WHEREAS the Medical and Chirurgical Faculty is made up of all the County and City Medical Societies

WHEREAS the Council is the policy-making body of the Faculty

WHEREAS a member of the Council should be truly representative of his area

WHEREAS nominations are now made without consulting the local society as to the qualifications of the nominee for the job

BE IT RESOLVED that the Nominating Committee select its nominees for the Council from elected representatives of the component societies, i.e., members of the House of Delegates.

The Resolutions Committee recommends that Resolution "B" be disapproved because it is our opinion that the resolution unnecessarily restricts the function of the Nominating Committee and that the addition to Resolution "A" (if approved by the House of Delegates) would render Resolution "B" less necessary.

BALTIMORE CITY MEDICAL SOCIETY

Resolution

WHEREAS, Past Presidents of the Medical and Chirurgical Faculty of the State of Maryland have held the highest post of honor in the Faculty, and should be above self-seeking or petty politics, and

WHEREAS, the best interest of the Faculty demand that men of this type be on the Nominating Committee each year, therefore

BE IT RESOLVED that the House of Delegates be requested to change the following sentence in Section 5, Chapter VIII of the By-Laws

"The President shall appoint, at the end of his term of office in December, a Nominating Committee of five members."

to read as follows:

"The Nominating Committee shall consist of the five most recent living Past Presidents of the Faculty."

Executive Board of the Baltimore City Medical Society
GRANT E. WARD, M.D., *President*
FRANCIS J. GERAGHTY, M.D., *First Vice President*
WHITMER B. FIROR, M.D., *Second Vice President*
JOHN N. CLASSEN, M.D., *Secretary*
ROBERT C. KIMBERLY, M.D., *Treasurer*
C. HOLMES BOYD, M.D.
HOUSTON S. EVERETT, M.D.
WILLIAM L. GARLICK, M.D.
AMOS R. KOONTZ, M.D.
LOUIS A. M. KRAUSE, M.D.
THEODORE H. MORRISON, M.D.

The Resolutions Committee recommends disapproval of this resolution because a Nominating Committee appointed, as suggested, would be less representative of the state as a whole than the committees that have been appointed under the system now in effect.

MARYLAND SOCIETY OF PATHOLOGISTS, INC.*

Resolution

WHEREAS the Baltimore City Medical Society by revision of the Constitution and By-Laws on November 20, 1953 holds that physicians who are "professionally active" are not eligible for associate membership and

WHEREAS it was the decision of the Executive Board of the Baltimore City Medical Society that the practice of pathology in the State of Maryland is included in the practice of medicine and that physicians practicing pathology are professionally active and, therefore, not eligible for associate membership and

WHEREAS the Maryland Society of Pathologists, Inc. approves the action of the Baltimore City Medical Society and

WHEREAS it is highly desirable that such regulation be applicable to all practicing pathologists in the State of Maryland,

THEREFORE, BE IT RESOLVED that the Maryland Society of Pathologists, Inc. do hereby petition and request that the Medical and Chirurgical Faculty of the State of Maryland resolve that the practice of pathology is included in the practice of medicine.

The Resolutions Committee recommends approval of this resolution. The resolution seems harmless and merely emphasizes a known fact that the Pathologists evidently feel would further their cause.

Respectfully submitted,
ROBERT VL. CAMPBELL, M.D., *Chairman*
ERNEST I. CORNBROOKS, JR., M.D.
MELVIN B. DAVIS, M.D.
ROBERT W. FARR, M.D.
JOHN D. YOUNG, JR., M.D.

COMMITTEE ON RURAL MEDICINE (1955)

Mr. President and Members of the House of Delegates:

This Committee reports that there were two main activities they were able to carry out during the year 1955.

1. An invitation to general practice, which was given by the

* Submitted for Maryland Society of Pathologists by the Secretary-Treasurer, Dr. Paul F. Guerin.

Chairman to the graduating class and interns at the University of Maryland Medical School in April 1955. This is an annual affair and was well attended.

2. On June 16 we organized a panel discussion at the Rural Woman's Short Course, University of Maryland, on two subjects. "What Makes for Good Health and Safety for Families and Communities" was the subject of the first panel. Dr. Aubrey D. Gates, Field Director, Council on Rural Health, American Medical Association, acted as moderator. For the first panel I arranged for Dr. Louis Krause and Dr. Perry Prather to speak, and Miss Florence Low arranged for Miss Janet Coblentz and Miss Agnes Beaton to complete that panel.

The subject of the second panel was "What Makes for Good Medical Care and How Do We Get It?" We secured the following speakers for this discussion: Mr. W. deV. Washburn, President of the American Health Insurance Corporation, Mr. Harvey Weiss, President of the Maryland-District of Columbia Hospital Association, and Dr. Louis Krause, and I completed that panel.

About 350 women, representing the 18,432 homemakers of all the counties and Baltimore City, attended this meeting. It was very enthusiastically received, and it is hoped that they returned to their counties and arranged for similar meetings. It might be pointed out that of the many questions which were directed to the panel, the most frequently asked concerned the lack of an adequate number of physicians, especially in the field of general practice. Almost every community represented had that complaint.

WE HAVE ALSO ARRANGED FOR A SERIES OF PROGRAMS ON "RURAL MEDICINE" SENT TO US BY THE AMERICAN MEDICAL ASSOCIATION. NEGOTIATIONS HAVE BEEN GOING ON WITH STATION WMAR FOR RADIO OR TV PRESENTATION.

Respectfully submitted,

PAGE C. JETT, M.D., *Chairman*
E. I. BAUMGARTNER, M.D.
MORRIS FRANKLIN BIRELY, M.D.
ARTHUR TALBOTT BRICE, M.D.
HENRY V. CHASE, M.D.
THOMAS A. CHRISTENSEN, M.D.
JOHN FAWCETT, M.D.
JESSE S. FIFER, M.D.
JOHN S. GREEN, III, M.D.
JOHN H. GRIFFIN, M.D.
JAMES W. MEADE, JR., M.D.
WALTER H. SHEALY, M.D.
MILFORD H. SPRECHER, M.D.
HUGH W. WARD, M.D.
JOHN WHITRIDGE, JR., M.D.
(1955 Committee)

COMMITTEE ON RURAL MEDICINE (1956)

Mr. President and Members of the House of Delegates:

1. The Organizational Meeting of this Committee was held at the Medical and Chirurgical Faculty Building, Wednesday, February 15, 1956, with the following members present, Dr. Archie R. Cohen, Chairman, Dr. Shepard Krech, Jr., Dr. Martin M. Rothstein, Dr. Walter H. Shealy, Dr. Gordon M. Smith, Dr. Hugh W. Ward.

2. The Chairman reviewed the history of the formation of this Committee in 1945, at the request of the American Medical Association and the reports of the various appointed committees from that date as submitted at the annual and semi-annual meetings to the present date.

3. The members then discussed the differences between the terms Rural Medicine and Rural Health, and it was felt that the function of our Committee is that of rural health, more specifically for the betterment of the health of the rural population of the State of Maryland.

4. The theme or motto of our committee will be *helping the community to help itself to better health.*

5. We hope to accomplish this by two means, both dealing in public education. The Committee will not make any decision for any community, but will act as a moderator, and possibly originator of plans for various exhibits, and a rural health conference, to be held once each year, in the State of Maryland.

6. In order to accomplish these aims, we, the Committee on Rural Medicine, request of the Medical and Chirurgical Faculty of the State of Maryland, the following:

A. THAT THE NAME OF THE COMMITTEE ON RURAL MEDICINE BE CHANGED TO THE COMMITTEE ON RURAL HEALTH, SO THAT OUR DUTIES AND FUNCTIONS MAY BE MORE CLEARLY DEFINED.

B. THAT PLANS BE INSTIGATED, THAT EACH COMPONENT MEDICAL SOCIETY, BE RESPONSIBLE, FOR A HEALTH EXHIBIT, AT THEIR VARIOUS COUNTY FAIRS. THIS EXHIBIT, TO BE PRESENTED YEARLY, ON VARIOUS ASPECTS OF HEALTH PROBLEMS. THE EXHIBIT TO BE ARRANGED UNDER THE AUSPICES OF OUR COMMITTEE, BUT TO BE MANNED BY THE COMPONENT MEDICAL SOCIETY, OR SOME GROUP RESPONSIBLE TO THEM, SUCH AS THE WOMAN'S AUXILIARY OF THE LOCAL SOCIETY.

C. THAT PLANS BE MADE FOR AN ANNUAL RURAL HEALTH CONFERENCE FOR THE STATE OF MARYLAND.

D. THAT THE COMPONENT MEDICAL SOCIETIES BE REQUESTED TO SET UP A COMMITTEE TO CORRESPOND TO THE STATE COMMITTEE ON RURAL HEALTH.

E. THAT, IN ORDER FOR THIS PROGRAM TO PROCEED IN AN ORDERLY MANNER, WITHOUT ANNUAL DISRUPTION, BECAUSE OF CHANGE IN MEMBERSHIP OF THIS COMMITTEE, THE COMMITTEE ON RURAL HEALTH BE COMPRISED OF SEVEN MEMBERS, ONE NEW MEMBER BEING ADDED EACH YEAR, THE CHAIRMAN BEING DROPPED, AND THUS EACH MEMBER WILL IN THIS MANNER WORK UP TO THE CHAIRMANSHIP OF THIS COMMITTEE IN HIS FINAL YEAR OF SERVICE.

7. It was felt, if the above be approved, by either the

Council of the Medical and Chirurgical Faculty, or the House of Delegates of the Faculty, since it is our impression, that we as a Committee do not have the authority to instigate this program, that we will then contact the various groups, and organizations, to coordinate their activities in a Rural Health Conference, in the Fall of 1956, with the motto for that meeting: *better health*, to myself, my family, and my community.

8. The next meeting of this Committee will be scheduled at the time of Annual Meeting, of the Medical and Chirurgical Faculty, if there is a report received from the Council, by that time.

Respectfully submitted,
ARCHIE R. COHEN, M.D., *Chairman*
SHEPARD KRECH, JR., M.D.
JAMES W. MEADE, JR.,* M.D.
MARTIN M. ROTHSTEIN, M.D.
WALTER H. SHEALY, M.D.
GORDON M. SMITH, M.D.
HUGH W. WARD, M.D.
(1956 Committee)

ADVISORY COMMITTEE TO THE STATE HEALTH DEPARTMENT (1955)

(The Committee to consist of the President, the President-elect, two past Presidents, the Secretary and four general practitioners, appointed by the President, of which one represents the Maryland Academy of General Practice.)

Mr. President and Members of the House of Delegates:

All the activities of this Committee have been duly reported and recorded in the minutes and proceedings of the Semi-annual Meeting in Ocean City, September, 1955. There were no activities of the Committee from the 1955 Semiannual Meeting to and including December 31, 1955.

Respectfully submitted,
BENDER B. KNEISLEY, M.D., *Chairman* (*President, 1954*)
MAURICE C. PINCOFFS, M.D. (*President, 1953*)
GEORGE H. YEAGER, M.D. (*President, 1955*)
President-elect (*Not elected until April 1955*)
EVERETT S. DIGGS, M.D., *Secretary*
Four General Practitioners:
LAURISTON L. KEOWN, M.D., *Immediate Past President of Maryland Academy of General Practice* (*1954*)
GERALD W. LEVAN, M.D.
ROBERT S. MCCENEY, M.D.
CHARLES H. WILLIAMS, M.D.
(1955 Committee)

ADVISORY COMMITTEE TO THE STATE HEALTH DEPARTMENT (1956)

Mr. President and Members of the House of Delegates:

It has been customary for this Committee to assemble members of the Committee and the appropriate officials of the State Department of Health when there is a need for discussing project or activities of the State Department of Health which may have a bearing upon the practice of medicine as it relates itself to State Health Department policies.

The purpose of this letter is to report that from January 1, 1956 until March 6 there has been no need for assembling such a meeting. Therefore, there is no formal report and summary of the activities of the Advisory Committee to the State Department of Health that I can make covering the period above.

Supplementary Report*

The Committee to Advise the State Department of Health met on April 15, 1956. As a result of the discussion at this time, the Committee wishes to submit the following recommendations:

1. THE COMMITTEE THEN AUTHORIZED DR. CHARLES F. O'DONNELL, A MEMBER OF THIS COMMITTEE, AND ALSO HAVING THE PRIVILEGE OF THE FLOOR AT THE HOUSE OF DELEGATES AS A DELEGATE, TO MOVE FROM THE FLOOR OF THE HOUSE OF DELEGATES, THAT THIS COMMITTEE BE CONTINUED, RATHER THAN TO ACCEPT THE REPORT OF THE COMMITTEE TO MAKE SURVEY OF COMMITTEES THAT THIS COMMITTEE BE ABOLISHED, AND FURTHER ADD THAT THIS COMMITTEE BE AUTHORIZED TO MEET ON THE CALL OF THE PRESIDENT OF THE MEDICAL AND CHIRURGICAL FACULTY, OR THE CHAIRMAN OF THE COMMITTEE, OR AT THE REQUEST OF THE STATE DEPARTMENT OF HEALTH.
2. THAT THE NAME OF THIS COMMITTEE BE CHANGED TO READ: *A COMMITTEE TO CONSULT WITH THE STATE DEPARTMENT OF HEALTH.*
3. THAT THE STATE HEALTH DEPARTMENT BE REQUESTED, THROUGH APPROPRIATE CHANNELS, TO PROMPTLY DISSEMINATE CHANGES IN PROCEDURE OR POLICY OF INTEREST TO PHYSICIANS TO ALL PHYSICIANS IN THE STATE OF MARYLAND.
4. IT IS RECOMMENDED THAT HEALTH OFFICERS IN MARYLAND REFRAIN FROM PUBLIC STATEMENTS THAT POLIOMYELITIS VACCINE IS AVAILABLE IN HEALTH DEPARTMENT CLINICS UNTIL SUCH A TIME AS WHEN SUFFICIENT VACCINE IS AVAILABLE TO THE PRIVATE PHYSICIANS.

Respectfully submitted,
WILLIAM H. F. WARTHEN, M.D., *Chairman* (*President, 1956*)
BENDER B. KNEISLEY, M.D. (*President, 1954*)
WALTER D. WISE, M.D. (*President, 1951*)

* Deceased.

* This committee met subsequently to mailing of Summary of Reports, and therefore these recommendations were not included in original report.

President-elect (Not elected until May 1956)
EVERETT S. DIGGS, M.D., *Secretary*
Four General Practitioners:
ARCHIE R. COHEN, M.D.
ROBERT S. MCCENEY, M.D.
CHARLES F. O'DONNELL, M.D. (*Maryland Academy of General Practice*)
EDWARD C. H. SCHMIDT, M.D.
(1956 Committee)

ADVISORY COMMITTEE TO THE STATE ACCIDENT FUND (1955)

Mr. President and Members of the House of Delegates:

The Committee was grieved by the sudden death on 23 April 1955 of Dr. George A. Stewart, who during the previous year had been appointed Medical Advisor to the State Accident Fund. Dr. Stewart had done a fine job during his short tenure of office and had been repeatedly highly praised by the Chairman of the Fund.

Upon Dr. Stewart's death the Fund again requested your Committee to submit two names from which they would select an advisor to the Fund. The Committee submitted the following names: Dr. Howard M. Kern, Dr. Harvey B. Stone. (Dr. Kern, as one interested in the position, did not sit in on the meeting of the Committee at which the names were selected.) Soon after these names were submitted to the Fund, that body selected Dr. Kern for the position. He assumed his duties on 1 July 1955.

Soon after assuming his duties, Dr. Kern became busily engaged with the concerns of the Fund and prepared a new bulletin containing instructions to physicians, dentists, nurses, and hospitals, relative to handling Fund cases. Dr. Kern submitted this bulletin to your Committee for its approval. The Committee studied it carefully, considered it excellent, and approved it in toto.

The Chairman of the Fund, while lamenting the death of Dr. Stewart, is highly pleased with the work that Dr. Kern is doing for that body, and has so expressed himself.

Respectfully submitted,
AMOS R. KOONTZ, M.D., *Chairman*
GEORGE O. EATON, M.D.
WILLIAM R. GERAGHTY, M.D.
DONALD B. GROVE, M.D.
HOWARD M. KERN, M.D.
RAYMOND E. LENHARD, M.D.
JOHN O. ROBBEN, M.D.
S. JACK SUGAR, M.D.
CHARLES C. ZIMMERMAN, M.D.
(1955 Committee)

ADVISORY COMMITTEE TO THE STATE ACCIDENT FUND (1956)

Mr. President and Members of the House of Delegates:

This Committee has very recently been appointed under my Chairmanship and up to this moment there has been no business brought up before it that has required a meeting.

Respectfully submitted,
RAYMOND E. LENHARD, M.D., *Chairman*
JAMES G. ARNOLD, M.D.
GEORGE O. EATON, M.D.
WILLIAM R. GERAGHTY, M.D.
DONALD B. GROVE, M.D.
H. ALVAN JONES, M.D.
HOWARD M. KERN, M.D.
GEORGE MCLEAN, M.D.
JOHN O. ROBBEN, M.D.
S. JACK SUGAR, M.D.
CHARLES C. ZIMMERMAN, M.D.
(1956 Committee)

TUBERCULOSIS COMMITTEE (1955)

Mr. President and Members of the House of Delegates:

This Committee held no meeting during the year.

Respectfully submitted,
LAWRENCE M. SERRA, M.D., *Chairman*
EDMUND G. BEACHAM, M.D.
OTTO C. BRANTIGAN, M.D.
A. MURRAY FISHER, M.D.
LEON H. HETHERINGTON, M.D.
H. VERNON LANGELUTTIG, M.D.
ISADORE B. LYON, M.D.
JOHN E. MILLER, M.D.
HUGH J. WELCH, M.D.
HUGH G. WHITEHEAD, M.D.
SAMUEL WOLMAN, M.D.
(1955 Committee)

TUBERCULOSIS COMMITTEE (1956)

Mr. President and Members of the House of Delegates:

This Committee met on 2 March, 1956, all members being present save one. Discussion followed the pattern of the previous committees and dealt mainly with what has been accomplished since the last report, also emphasis was given to several new concepts which have arisen.

1. The present waiting lists for hospitalization of the tuberculosis is very low and in most instances ten days represents the maximum waiting period. This is a very real accomplishment and shows great improvement over the situation in the past. The Admission of Negroes to the State Sanatorium system, especially Mt. Wilson, is being carried out. The admission of Negro children to Eudowood has eased the situation at Henryton Sanatorium. Likewise, it was brought out that Eudowood accepts Private Negro patients.

2. Both Mt. Wilson and Baltimore City Hospitals have elaborate Surgical facilities, but to date no use has been made of them, and none will be made in the foreseeable future. This situation is due mainly to the lack of trained Professional personnel and the inability to obtain same, even though funds are available.

3. Legislation has been passed whereby forced hospitalization, and/or incarceration of the recalcitrant patient may be accomplished. However, there seems to be some difference of opinion as regards this matter between the State Health

authorities and the City Health authorities. The Committee, almost as a whole, regards that a "get tough policy" is a necessary prerequisite to the ultimate aim in the eradication of tuberculosis. There is about 20% of irregular discharges distributed amongst the various facilities for treating tuberculosis. It is conceded that this group constitutes a large pool of infection. The Committee passed a resolution that the City and the State Health authorities get together in setting up a more uniform policy concerning the infectious cases. It was also agreed that a copy of this resolution be passed on to the Veterans Administration in Washington, D. C., in as much as the Veteran Facilities in care of the tuberculosis also have an appreciable discharge rate.

4. Morbidity figures recently published by the City Health Department show a 15% decline in the tuberculosis rate for the year 1955. The same is not true, however, as regards the counties; there being a slight increase for the years 1954 and 1955. The City Health report was given wide coverage in the press, and it is feared that this may lull the community, both lay and professional, into a false sense of security with a resulting relaxation in our present methods of case-finding. Likewise, it is feared that should this occur public apathy may result in decreased funds being made available. It is felt that the slight increase in new cases found by the State Health Department is due to continued pressure on contacts, etc.

5. The question of morbidity is considered a relative one and the answer may lie in the fact that too many cases are not being reported as required by law. This can be laid directly in the hands of our hospitals and physicians. The Committee therefore recommends that all hospitals, private laboratories and physicians be made cognizant of these facts and be stimulated to report positive sputum or gastric aspirations, also to report suspected cases of tuberculosis. There are probably many more unknown cases of tuberculosis than known cases. In 1954 and 1955 about 30% of the patients who died from tuberculosis were not reported until the death of the patient. The Committee recommends that a copy of this resolution be sent to each physician, hospital, and private laboratory in the State.

6. THE COMMITTEE AGAIN RECOMMENDS THAT ALL HOSPITALS IN THE STATE REQUIRE ROUTINE CHEST FILMS OF ALL PATIENTS ON ADMISSION. IT HAS BEEN THE EXPERIENCE OF MANY OF US THAT PATIENTS WITH ACTIVE LESIONS ARE FREQUENTLY ADMITTED TO SURGICAL WARDS AND EVEN TO PRIVATE ROOMS FOR SURGICAL PROCEDURES AND GO UNDISCOVERED, THUS EXPOSING OUR HOSPITAL PERSONNEL TO INFECTION. THIS CERTAINLY CAN BE WORKED OUT SINCE A LARGE NUMBER OF PATIENTS HAVE BLUE CROSS INSURANCE AND FOR THOSE FEW WHO DO NOT, AND ENGAGE A PRIVATE ROOM, THE COST SHOULD NOT BE BURDENSOME.

Respectfully submitted,

H. Vernon Langeluttig, M.D., *Chairman*
Edmund George Beacham, M.D., *Vice-Chairman*
Otto C. Brantigan, M.D.
R Adams Cowley, M.D.
Leon H. Hetherington, M.D.
Milton B. Kress, M.D.
John E. Miller, M.D.
Lawrence M. Serra, M.D.
Charlotte Silverman, M.D.
Hugh G. Whitehead, Jr., M.D.
Samuel Wolman, M.D.
(1956 Committee)

COMMITTEE ON VETERANS' MEDICAL CARE (1955)

Mr. President and Members of the House of Delegates:

The Committee on Veterans Care of the Faculty did not meet during 1955.

The main problem confronting the Committee before this was the use of a 10 P 10 form requiring an itemized financial position of the veterans under oath for admission to a veterans hospital. A new form is now in use which clarifies the veterans' inability to pay, and should reduce the load in veterans' hospitals. A trial with this form seemed advisable before further action should be taken.

Dr. Koontz I am sure is quite aware of this problem.

Respectfully submitted,

Ralph G. Hills, M.D., *Chairman*
Ernest I. Cornbrooks, Jr., M.D.
Raymond M. Curtis, M.D.
R Walter Graham, Jr., M.D.
Harry C. Hull, M.D.
Amos R. Koontz, M.D.
(1955 Committee)

COMMITTEE ON VETERANS' MEDICAL CARE (1956)

Mr. President and Members of the House of Delegates:

This Committee has held only one meeting during the current year (1956). That meeting was held on 24 February. Since the first of the year the Chairman of your Committee has been in correspondence with Dr. Louis M. Orr, Chairman of the A.M.A. Committee on Federal Medical Services, in order to find out what had been done at the national level since last year. It was determined that very little had been done because the A.M.A. officials had been in conference with officials of the American Legion hoping that they could formulate a common policy with regard to the medical care of veterans. Apparently this effort did not meet with the success that was initially hoped for.

At the meeting on 24 February, consideration was given to a report on a Chicago Conference of State Committees on Medical Care of Veterans, which was held on 19 February 1955. The report was made by the member of the Committee (now the Chairman) attending the Conference, soon after his return therefrom. The Committee decided to adopt the report and make it a part of *this* report. The report is given in full below and ***it is recommended that the recommendations contained therein be adopted by the House of Delegates.***

At the meeting of 24 February, the Committee also reviewed certain data on the medical care of veterans which had been collected by the Chairman and decided to send these data

with the report of the Chicago meeting to each member of the Faculty for their information.

The Committee decided to take measures to secure legislative action on some of the recommendations in the Report referred to, after the House of Delegates has acted on them. In the meantime, the Committee will endeavor to put into effect such of the recommendations as do not require House of Delegates action.

The following is the Report with its recommendations:

REPORT ON CHICAGO MEETING

Conference of State Committees on Medical Care of Veterans

February 19, 1955

Amos R. Koontz, M.D.

The Problem of Service Presumption.—Multiple sclerosis, tuberculosis, psychoses, and other diseases, are presumed to be service connected if they made their appearance within a certain length of time after the veteran left the service. If the present trend continues, undoubtedly subsequent Congresses will add new diseases to the list and increase the length of time after discharge from the service for which service presumption is allowed. The question is whether the matter of service presumption should be one of legislative fiat or of medical opinion.

It is proposed that the A.M.A. offer committees of doctors to pass on service presumption, free of charge, and eliminate legislative fiat altogether. The men on these committees could be rotated so as not to make it too burdensome. This, of course would require a change in the law. The American Legion employs a physician as a lobbyist for them in Washington, who is very clever at working on the feelings and sensibilities of Congressmen and getting them to pass bills such as the multiple sclerosis bill, and in increasing the service presumption time.

Only recently were we able to get a bill passed limiting service presumption so far as teeth were concerned to six months after discharge from the service. Prior to that if a man had a record of any dental defect while he was in the service, he could get continuous dental care no matter how long after he left the service. Over half the dentists were on the pay roll for this, so they would not fight the bill. When this bill was repealed and the service presumption limited to six months, 600,000 veterans were removed from Federal largess.

Home Town Care Program.—A great deal of veterans' service connected care was being done in local towns by private physicians and some is still being so done. However, the Veterans Administration in a great many localities has arbitrarily cancelled the provisions for it. Recently a ruling was passed that 13 procedures, such as intravenous pyelogram for instance, had to be done in hospital instead of in doctors offices. An intravenous pyelogram, which could be done very simply in a doctor's office, now requires admission to a Veterans Hospital and the patient is kept in six days for it. Very frequently his dependents go on relief while he is in the hospital.

In order to get home town care, a veteran must have a service connected disability. We should keep it that way in order to strengthen our position. However, this means that veterans with non-service connected disabilities by some pretext or another get into a hospital to have their ailments taken care of. If a patient with a non-service connected disability has a disabling operation or accident while he is in the hospital, even though it has no connection with his service, he may become a service connected patient for that disability and, if so, is carried so for the rest of his life. He also may get a pension for it. For instance, if his rectum is accidentally punctured during proctoscopy, or something of that sort, he reaps all the benefits. If he has a partial gastrectomy for peptic ulcer, he gets a pension because of disability and becomes a service connected case.

Information.—We should have more information in concise form sent us by the National Committee on Federal Medical Services. We should print in the State Medical Journal each month information furnished in the "Blue Letters."

Positions of Legislators.—The private physicians, or a close personal friend of each legislator, should be on our Veterans' Medical Care Committees and should keep the committees informed as to the thinking of that particular legislator.

Stay in Hospital.—It was pointed out that a patient might go into the Cincinnati General Hospital, for instance, for a certain condition for a period of ten days and the average cost would be $160. If a veteran went into a Veterans Administration Hospital for the same condition, his stay would be 38 days at an average cost of $750. The same doctors who treated the patient in the Cincinnati General Hospital would also treat the patient in the Veterans Administration Hospital as consultants.

Patients with non-service connected disabilities cannot get out-patient service. Therefore, they stay in Veterans Administration hospitals much longer than necessary so that they will not have to have any treatment after they leave the hospital.

Tropical Diseases.—In 1948 fifteen tropical diseases were declared by Congress to be service connected, if shown to exist within one year after separation from active service, or at a time when standard and accepted treatises indicate that the incubation period thereof commenced during active service.

Non-Service Connected Cases Who Cannot Afford Private Hospitalization.—Recently a man with a non-service connected disability, who was driving a Cadillac car, claimed that he could not afford to have his operation in a private hospital. His word had to be taken and (as provided by law) he was admitted to a Veterans Administration hospital. Also recently a man was taken into a private hospital drunk. It was found that he had $3,900 in his pocket. However, because he was a veteran, he was removed to a Veterans Administration hospital, although it was obvious that his condition (drunkenness) was not service connected.

Residency Training Program.—In order to keep the residency training program going, Veterans Administration hospitals are kept stocked with patients with non-service connected disabilities. The most recent estimate is that 87% of the patients in Veterans Administration hospitals have non-service connected disabilities.

Meeting With American Legion Officials.—On 17 February 1955 officials of the A.M.A. had a meeting with officials of the American Legion. Both agreed not to divulge their agreements until a little later. However, the A.M.A. officials assert that it was the most encouraging meeting ever held with any veterans organization and that both organizations were in agreement on all subjects discussed, except the matter of making a special class out of veterans. The American Legion feels that any man who has worn the uniform should be set apart as a special privileged class of citizen. The A.M.A., as well as several past national administrations, hold that to serve in the armed forces is the duty of a citizen and that he should have no special reward for it, except that if he is disabled while he is in the service, he should have care for his disability at government expense.

Recommendations.

1. PRINT INFORMATION CONTAINED IN "BLUE LETTERS" IN THE STATE MEDICAL JOURNAL EACH MONTH.
2. HAVE THE PRIVATE PHYSICIAN, OR SOME CLOSE DOCTOR FRIEND OF EACH LEGISLATOR, ON THE STATE VETERANS' MEDICAL CARE COMMITTEE.
3. HAVE OUR HOUSE OF DELEGATES INSTRUCT OUR DELEGATES TO THE A.M.A. HOUSE OF DELEGATES TO ADVOCATE THE FORMATION OF SERVICE PRESUMPTION COMMITTEES OF PHYSICIANS, IN ORDER TO DETERMINE WHAT CASES ARE SERVICE PRESUMPTIVE, AND WHOSE SERVICES WILL BE OFFERED IN LIEU OF LEGISLATIVE FIAT.
4. DOCTORS WHO ARE VETERANS SHOULD JOIN THE AMERICAN LEGION AND WORK FROM WITHIN THE LEGION, AS WELL AS FROM WITHOUT IT, TO PREVENT VETERANS ABUSES OF MEDICAL CARE.
5. THAT WE PROTEST AGAINST THE PRACTICE OF NO INVESTIGATION OF FINANCIAL STATUS OF VETERANS APPLYING FOR HOSPITALIZATION IN VETERANS ADMINISTRATION HOSPITALS FOR NON-SERVICE CONNECTED DISABILITIES.
6. THAT OUR HOUSE OF DELEGATES APPROVE THIS REPORT, ADOPT ITS RECOMMENDATIONS, AND SO INFORM ALL MEMBERS OF CONGRESS FROM MARYLAND.

Respectfully submitted,

AMOS R. KOONTZ, M.D., *Chairman*
ERNEST I. CORNBROOKS, JR., M.D.
RAYMOND MILLER CURTIS, M.D.
FRANCIS G. DICKEY, M.D.
H. VERNON LANGELUTTIG, M.D.
S. EDWIN MULLER, M.D.
HARRY P. PORTER, M.D.
RAYMOND C. V. ROBINSON, M.D.
GEORGE H. YEAGER, M.D.
(1956 Committee)

Statement on Report of Committee on Veterans' Medical Care to the House of Delegates of Medical and Chirurgical Faculty (May 4, 1956)

ROSS L. MCLEAN, M.D.

1.) On behalf of, and at the request of the Council of the Medical and Chirurgical Faculty, Dr. Ross L. McLean, member of Council and Director, Professional Services Veterans' Administration Hospital, submitted the report of the Committee on Veterans' Medical Care to the Deputy Chief Medical Director of the Veterans Administration in Washington, D. C. for specific factual data relative to selected items contained within the Committee's Report.

2.) Pertinent excerpts from Dr. McLean's covering letter to the Deputy Chief Medical Director are as follows:

"The attached Report of the Committee on Veterans' Medical Care came before a meeting of the Council on April 24, 1956. It will be presented to the House of Delegates for action May 2, 1956. It is presented to your office at this time by Dr. McLean at the request of the Council and on behalf of the Council rather than as an independent action by Dr. McLean or the management of this hospital."

"Specific comment regarding the factual content of this report which may be offered by your office, or your designate, will be submitted to the Executive Committee and to the Council as soon as it becomes available."

"It should be emphasized that no effort is being made to enter into controversy with individuals responsible for the attached committee report or with the State Medical Society. The sole purpose of this request is to provide the Executive Committee and the Council with confirmed factual data directly from official sources in order to assist them in evaluating the attached committee report and in advising the forthcoming meeting of the House of Delegates."

3.) The specific statements on which factual data was requested and the specific information developed by the office of the Deputy Chief Medical Director is reproduced verbatim herewith:

Statement (*a*) That service presumption is being provided by Congress for additional diseases at the approximate rate of one a year.

Comment (*a*) PL 748, 80th Congress (1948) and PL 239, 82nd Congress (1951) are the only two basic laws so far passed which provide for presumptive period for certain diseases and conditions which shall be accorded service connection by the Veterans Administration when shown to exist within the time limitations specified. (It is to be noted that PL 239 is concerned solely with treatment.)

Statement (*b*) That service presumption is being increased gradually, a year at a time for diseases already legislated for.

Comment (*b*) Only one extension has been made to the original presumptive period declared by PL 748, referred to above, for two conditions, namely multiple sclerosis and active tuberculosis.

Statement (*c*) The legal area in which a proposed committee

of physicians could pass upon service presumption and eliminate legislative fiat.

Comment (*c*) Within the limitation of the statutes, the Administrator of Veterans Affairs has the responsibility for the determination of service connection. This responsibility is delegated by him to the Rating Boards. Even though there may be no further legislation establishing presumptive periods for service connection, the Veterans Administration could not be bound by a body such as the proposed committee of physicians, nor any other body outside the Veterans Administration, although it could take into consideration any recommendations submitted in connection with a specific condition or category of conditions. Thus there appears to be no legal area, in the strict sense, for the services of such a proposed group in order to supplant the type of legislative action with which the report is concerned. The Veterans Administration has an advisory group available to it, the Special Medical Advisory Group (established by PL 293, 79th Congress), which advises the Administrator on medical matters, to which problems concerning diseases which may be added to the presumptive group as provided in PL 748, 80th Congress, may be referred.

Statement (*d*) That there has been arbitrary cancellation of provisions for home town care and office diagnostic procedures.

Comment (*d*) General Instructions to the field are based on recommendations by consultants in the various specialties and on acceptable medical standards. They cite that procedures requiring general anesthesia will not be done nor shall any therapeutic or diagnostic procedure be performed that may, on basis of history or other indication, be followed by severe systemic reaction, delayed severe allergic reaction or delayed severe secondary hemorrhage. Diagnostic and therapeutic procedures which will not under any circumstances be performed in outpatient clinics are cited in M2—Part I, Chapter 7.

Statement (*e*) That a hospitalized non-service connected patient may automatically become service connected as a result of a disabling operation or accident while hospitalized for a non-service connected condition.

Comment (*e*) A non-service connected patient does not automatically become service connected by receiving a disabling condition as a result of an operation as cited. However, if an accident occurs, resulting in a disabling condition which is proven to be the result of carelessness, accident, negligence, error in judgment, etc., the patient may file claim, and if adjudicated in his favor, service connection could result.

Statement (*f*) That recently 15 tropical diseases have been declared service connected without regard to time of appearance following discharge from service.

Comment (*f*) PL 748, 80th Congress (1948) provides that the diseases listed therein (including the tropical disease conditions referred to) "shall be accorded service connection when shown to exist within one year after separation from active service *or at a time when standard and accepted treatises indicate that the incubation period thereof commenced during active service.*" (Italics added)

Statement (*g*) A statement regarding the limits of authority of hospital management to investigate the financial claims of individuals applying for hospitalization for non-service connected disability.

Comment (*g*) The basic statute authorizing hospital, medical and domiciliary care for veterans is Section 6, Public No. 2, 73rd Congress, as amended, (38 U.S.C. 706), which includes the following proviso relating to these benefits for war veterans with non-service-connected disabilities, the pertinent part of which reads as follows:

"Provided, That any veteran of any war who was not dishonorably discharged, suffering from disability, disease, or defect, who is in need of hospitalization or domiciliary care and is unable to defray the necessary expenses therefor (including transportation to and from the Veterans' Administration facility), shall be furnished necessary hospitalization or domiciliary care (including transportation) in any Veterans' Administration facility, within the limitations existing in such facilities, irrespective of whether the disability, disease, or defect was due to service. The *statement under oath* of the applicant on such form as may be prescribed by the Administrator of Veterans' Affairs *shall be accepted as sufficient evidence of inability to defray necessary expenses.*"

In view of the italics (above) language of the applicable statute, *the Veterans Administration is precluded from investigating the financial claims of eligible individuals applying for hospitalization for non-service-connected disabilities.* However, under the broad powers granted to the Administrator, he has, under date of November 4, 1953, required that in addition to VA Form 10-P-10, Application for Hospital Treatment or Domiciliary Care, veterans who sign the oath will submit, in addition to the statement of inability to pay, an addendum to that application, wherein such individuals will give an accounting of their current financial status. This latter requirement is for application only with respect to veterans seeking hospitalization for treatment of non-service-connected conditions and who are not in receipt of compensation from the Veterans Administration for a compensable service-connected condition. The addendum to VA Form 10-P-10 prescribed in Circular No. 11 dated November 4, 1953 was designed primarily to cause each applicant for hospitalization to focus his attention on his financial status, and thereby give him a clearer understanding on the propriety of signing the oath of inability to pay.

Prior to the release of Circular No. 11, Managers of VA hospitals were requested to submit to the Central Office all applications of veterans hospitalized for treatment of non-service-connected conditions on and subsequent to March 27, 1953 where there was reasonable evidence to believe that the statement under oath with respect to ability to pay was questionable. Managers were, however, in view of the language of the statute, cautioned that *no investigation of any case will be made or requested at the local level and no report of them will be made to any other Government agency or official except as authorized by the Central Office.* This was necessary in view of the specific language in the statute which provides that the veteran's statement under oath

shall be accepted as sufficient evidence of inability to defray the cost of hospitalization.

Statement (*h*) That Veterans Administration Hospitals are being kept stocked with patients with non-service connected disability in order to maintain the Residency Training Program.

Comment (*h*) The statements contained in Dr. Hawley's (Chief Medical Director, Department of Medicine and Surgery) letter of October 9, 1947, are as applicable today as they were when written. A copy of the letter is attached.

October 9, 1947

"TO: All Branch Medical Directors

I desire that you bring to the attention of each manager, and that he bring to the attention of his professional staff, both full-time and part-time, this statement of policy:

From time to time, complaints have reached me that the principal criterion applied to applications for hospitalization, especially by teaching hospitals, is the suitability of the applicant for teaching purposes. I have previously announced the policy of the Department of Medicine and Surgery upon this subject, but continuing complaints make it necessary that I repeat it.

'The sole criteria to be applied to all applications for hospitalization are the legal requirements for admission and the necessity for hospitalization.

Teaching programs in our hospitals were established for the primary purpose of raising the standard of the medical care of the veteran. They will survive or perish solely upon this principle. Let no one think for one minute that the veterans or the country will tolerate these programs upon any other basis. The veteran is a private patient, the costs of his medical care are paid for by the Government, and he has not the slightest obligation to pay any part of his care in terms of his usefulness as a subject for teaching.'

I have been unable to find any case in which a veteran was, in fact, denied hospitalization for such a reason; but I have confirmed incidents in which ill-advised statements to this effect were made by irresponsible physicians, both full-time and part-time. Such statements not only prejudice the success of the program of the Department of Medicine and Surgery, but are also highly injurious to the good name of medicine in this country—and at a time when medicine cannot afford to lose any more friends.

Repetitions of such violations of my expressed policy of the Department of Medicine and Surgery force me to state that, in the future, I shall have to take appropriate action in cases of this nature.

Very truly yours,
PAUL R. HAWLEY
Chief Medical Director"

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY (1955)

Mr. President and Members of the House of Delegates:

During the year, 1955, the Committee has stood by to be of help when requested by the officers of the Woman's Auxiliary. On several occasions matters have arisen upon which advice has been sought and through the Chairmen advice has been given, either verbally or in writing. Requests from the National Auxiliary are occasionally received by the State organization which require some local interpretation. Other matters relating to policy, such as public relations, legislative activities and finances have been referred to the Council, through the President of the Faculty. Always the officers of the Auxiliary have shown a cooperative desire to demonstrate the real reason for their existence which is "to assist the medical society in its program for the advancement of medicine and public health."

Respectfully submitted,
SAMUEL MCLANAHAN, M.D., *Chairman*
ALBERT E. GOLDSTEIN, M.D.
JOHN G. BALL, M.D.
(1955 Committee)

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY (1956)

Mr. President and Members of the House of Delegates:

This Committee has had no formal meetings, but several matters have come to our attention. These have been taken care of by telephone and correspondence.

We have given our unanimous approval for the Woman's Auxiliary to revise their Constitution, so that the Auxiliary can obtain a tax free status; whereby the Government and every one else can clearly see that the Woman's Auxiliary is an "Eleemosynary" society—educational, charitable, non-profit Organization.

The Committee feels that when the Council representing the Medical and Chirurgical Faculty of the State of Maryland takes action on Legislation, would this body approve of the Woman's Auxiliary taking similar action, after having checked with the Advisory Committee to the Auxiliary, concerning this Legislation, and then proceed to take action.

The Committee approved that the Woman's Auxiliary, with a membership of 508, write to their Senators and Representatives opposing the passage of Bill H. R. 7225.

Although not a recommendation, this Committee is requesting instructions from the House of Delegates.

Respectfully submitted,
O. H. BINKLEY, M.D., *Chairman*
JOHN G. BALL, M.D.
J. ALBERT CHATARD,* M.D.
MERRILL M. CROSS, M.D.
ERNEST F. POOLE, M.D.
GEORGE H. YEAGER, M.D.
(1956 Committee)

COMMITTEE TO STUDY PROBLEM OF ACCREDITATION OF HOSPITALS

(Appointed by the President of the Faculty as authorized by the House of Delegates, April 1955.)

Mr. President and Members of the House of Delegates:

The recommendations made by the Committee on Accreditation of Hospitals, Residency and Intern Training were

* Deceased.

presented to the Council of the Medical and Chirurgical Faculty December, 1955, and after being approved with minor changes were forwarded to the Joint Commission on Accreditation of Hospitals and the Council on Medical Education and Hospitals of the A. M. A.

A letter of acknowledgment came on January 13, 1956 from Dr. Edward H. Leveroos, Director of the Council on Medical Education and Hospitals. He expressed the view that he thought the report of the Committee was a very worthwhile one, and that it would provide a sound basis for the Council and Residency Review Committees in evaluating their program.

On March 7, 1956, a letter was received from Dr. John Hinman, Acting Committee Secretary to the effect that the Residency Review Committee on Internal Medicine, had reviewed the recommendations of our Committee and wished to express thanks for the report, which they felt to be thoroughly sound. The letter also informed us that the Residency Review Committee was in the process of developing more detailed requirements for Residency Training and that the Committee would also support the recommendations which had been made by our Committee as to accurate evaluation, adequate prior notification to hospitals of criticisms, and mechanism to alleviate problems on the status of Residents.

I have been told also unofficially by different people who have been in Chicago that reorganization of the whole Accreditation System is being effected and that the recommendations of our Committee will be given great consideration in this reorganization.

It is my opinion that the work of this Committee is finished and I would suggest that it be discharged, unless it is the feeling that it should continue until final action on our recommendations is carried out by the national accrediting bodies.

Respectfully submitted,
HERBERT E. WILGIS, M.D., *Chairman*
ROBERT L. BAKER, M.D.
OTTO C. BRANTIGAN, M.D.
LEWIS P. GUNDRY, M.D.
HOWARD W. JONES, JR., M.D.
LOUIS KRAUSE, M.D.
WALDO B. MOYERS, M.D.
WILLIAM S. MURPHY, M.D.
STEDMAN W. SMITH, M.D.

COMMITTEE TO CONFER WITH BLUE CROSS AND BLUE SHIELD IN REGARD TO RADIOLOGICAL SECTION RESOLUTION

(Appointed by the President of the Faculty as authorized by the House of Delegates, April 1954.)

Mr. President and Members of the House of Delegates:

This Committee wishes to report some progress in its long negotiations with the administrators of Maryland Blue Cross and Blue Shield. This is in the form of a recent announcement by Blue Shield of its extended coverage to include x-ray therapy and emergency accident x-ray coverage. Although these items have been included in other Blue Cross-Blue Shield programs throughout the country for many years, their belated appearance in Maryland is none the less encouraging.

A number of problems remain unsolved. The Committee feels that direct negotiation with the administrators of Maryland Blue Cross and Blue Shield at this time would have little chance of success. A more sympathetic atmosphere is necessary for these negotiations; and, with the support of the State Medical Society, it is felt this can be accomplished in the not too distant future.

Since the primary purpose of this Committee has been accomplished with the passage of the Radiological Section Resolution at the 1955 semi-annual meeting, IT IS SUGGESTED THAT THE COMMITTEE BE DISCHARGED UNDER ITS PRESENT TITLE and that, in accordance with the above-mentioned resolution, a new committee be appointed to implement the resolution. It is further suggested that, in the beginning, this new Committee consist essentially of the same membership, who are conversant with the problems involved.

Respectfully submitted,
EDGAR T. CAMPBELL, M.D., *Chairman*
WEBSTER H. BROWN, M.D.
GEORGE G. FINNEY, M.D.
I. RIVERS HANSON, M.D.
HENRY L. WOLLENWEBER, M.D.

COMMITTEE FOR BETTER DISTRIBUTION OF DOCTORS THROUGHOUT THE STATE (1955)

(Appointed by the President of the Faculty as authorized by the House of Delegates, September 1952.)

Mr. President and Members of the House of Delegates:

In the Spring of 1955, I submitted my resignation as Chairman of this Committee in view of a rather prolonged illness during the previous winter and since full reports had been previously submitted with no active response forthcoming. I felt, therefore, that someone else should be made Chairman in order to bring other ideas into the picture. Consequently no activity was carried out by the Committee in 1955. I have conferred recently with the new Chairman, Dr. Edward Jarrett, and have given him the benefit of all information at my disposal.

Respectfully submitted,
ALLEN F. VOSHELL, M.D., *Chairman*
E. I. BAUMGARTNER, M.D.
A. M. FRANCE, M.D.
DAVID J. GILMORE, M.D.
EDWIN B. JARRETT, M.D.
LOUIS ROBERT SCHOOLMAN, M.D.
(1955 Committee)

COMMITTEE FOR BETTER DISTRIBUTION OF DOCTORS THROUGHOUT THE STATE (1956)

(Appointed by the President of the Faculty as authorized by the House of Delegates, September 1952.)

Mr. President and Members of the House of Delegates:

This Committee met in March 1956. The Chairman gave a review of the proceedings and recommendations of the previous

Committee by way of introduction and as a matter of orientation for the members. It was quite obvious to all that in theory the Faculty should do what it can to facilitate a community in securing proper medical care, as well as to assist physicians in finding desirable locations in which to practice. There followed a very interesting and revealing discussion. It was apparent there are many facets to this project that must be considered in determining the actual need for a physician in a given community and still more in evolving practical plans whereby that need can be satisfactorily met. It was well recognized that both of these procedures can be as complicated as they are difficult.

It was the consensus of opinion that there are few if any communities in the State of Maryland that are, at the present time, actually suffering from inadequate medical care, with the exception of Allegany and Garrett Counties which constitute a special problem.

The Committee then considered the setup in the Commonwealth of Virginia. Mr. Kirkman filled in the details. In that Commonwealth, with one hundred counties, a continuing shortage of doctors in the mountainous districts was a very real hazard. The State Medical Society in conjunction with interested social divisions on the State level has evolved an efficient working plan. The other agencies include the Welfare Department and the State Boards of Health, Mental Hygiene, and Education. All of them share the budget expense. The budget covers operating personnel consisting of a Director and two or more Assistants, with clerical help. The over-all amount is approximately $25,000 per annum. With a set up like this the Commonwealth maintains contact with the communities and physicians involved in each placement. The fifteen or more counties of the mountainous areas currently have better medical care.

A few scattered localities known to the members of this Committee, together with excellent roads and communications throughout our state do not seem to justify an all out attempt at doctor placement at this time.

The following recommendations are made after careful consideration:

1. WITH REGARD TO EXECUTION OF THESE RECOMMENDATIONS, THIS COMMITTEE IS HEARTILY IN AGREEMENT WITH THE RECOMMENDATIONS OF THE VOSHELL COMMITTEE OF 1954 IN THAT IT SEEMS PROPER THAT THE DIRECTOR OF THE FACULTY "BE ASSIGNED TO ACT AS DIRECTOR OF THE SERVICES" INCIDENT TO THESE RECOMMENDATIONS.
2. IT IS DEEMED UNNECESSARY AT THIS TIME TO SET UP AN ELABORATE AND CONSEQUENTLY EXPENSIVE PLAN OF PHYSICIAN PROCUREMENT AND REPLACEMENT SIMILAR TO THE VERY EXCELLENT ONE IN VIRGINIA.
3. FUNDAMENTALLY THE PROBLEM CONSTITUTES ONE OF SUPPLY AND DEMAND:
   (A) WITH REGARD TO *DEMAND*:
      (1) IT IS PROPOSED THAT EACH COUNTY MEDICAL SOCIETY OFFICIALLY AND ANNUALLY SURVEY ITS NEED FOR MEDICAL PRACTITIONERS AND REPORT TO THE COMMITTEE FOR BETTER DISTRIBUTION OF DOCTORS THROUGHOUT THE STATE.
      (2) FURTHER THAT ANY COUNTY MEDICAL SOCIETY REPORTING A PHYSICIAN LACK, PUBLISH ITS REPORT IN AN APPROPRIATE COUNTY NEWSPAPER(S). THIS IS TO GIVE NOTICE TO THE COUNTY AND/OR COMMUNITY AUTHORITIES OF THEIR FINDINGS AND FORMS A BASIS FOR GOOD PUBLIC RELATIONS ACTIVITIES AS A START TOWARD OBTAINING A PRACTITIONER.
      (3) FURTHER, THAT THE FACULTY THROUGH ITS DIRECTOR, AS ADVISED BY THIS COMMITTEE, WILL PROVIDE EACH COUNTY MEDICAL SOCIETY OR COMMUNITY ON REQUEST WITH DATA ABOUT WHAT IT TAKES TO ATTRACT AND SUPPORT A PHYSICIAN AND TECHNICAL DATA ABOUT BASIC FACILITIES INVOLVED.
      (4) FINALLY, THAT WHEN REALISTIC OPPORTUNITIES ARE FORTHCOMING THEY WILL BE LISTED BY THE FACULTY, THROUGH THE DIRECTOR, AS ADVISED BY THIS COMMITTEE, TO APPROPRIATE CENTERS WHERE THEY WILL BE BROUGHT TO THE ATTENTION OF PHYSICIANS WHO MAY BE SEEKING PRACTITIONER OPENINGS.
      (5) BUDGETARY REQUIREMENTS PER ANNUM FOR THIS SERVICE ARE NOT EXPECTED TO EXCEED $50.00 IN DIRECT OUTLAY FOR POSTAGE AND STATIONERY.
   (B) WITH REGARD TO *SUPPLY*:
      (1) OFFICIAL COMMENDATION SHOULD BE EXTENDED BY THE FACULTY TO THE UNIVERSITY OF MARYLAND MEDICAL SCHOOL FOR ITS ACTIVITY AND FORESIGHT IN ESTABLISHING AND DEVELOPING GENERAL PRACTICE INTERNESHIPS AND RESIDENCIES IN ITS POSTGRADUATE TRAINING.
      (2) AN ATTEMPT SHOULD BE MADE BY THE FACULTY TO ESTABLISH UNDERGRADUATE PRECEPTORSHIPS IN CONJUNCTION WITH MEDICAL SCHOOLS. THE FACULTY, THROUGH THE DIRECTOR, ADVISED BY THIS COMMITTEE, SHOULD SECURE THE SERVICES OF ACTIVE PRACTITIONERS QUALIFIED TO TAKE UNDERGRADUATE MEDICAL STUDENTS IN A PRECEPTOR STATUS AND COOPERATE IN THE PLACEMENT OF STUDENTS IF ARRANGEMENTS CAN BE MADE TO INCLUDE SUCH APPRENTICE-TRAINING IN THE MEDICAL SCHOOL CURRICU-

LUM, OR DURING THE SUMMER MONTHS.

(3) PUBLIC RELATIONS DIRECTED TOWARD BRINGING TO THE ATTENTION OF MEDICAL STUDENTS THE OPPORTUNITIES FOR SERVICE IN RURAL PRACTICE SHOULD BE DEVELOPED. A METHOD IN USE IN OTHER COMMUNITIES IS THAT OF A PANEL OR FORMAL LECTURE WHERE PROPONENTS OF THE MEDICAL SPECIALTIES, INCLUDING GENERAL PRACTICE AND RURAL MEDICINE, ARE PRESENTED AS A TEACHING CLINIC TO THIRD AND FOURTH YEAR STUDENTS. AFTER THE SPEAKERS FOR THE VARIOUS PRACTICES HAVE PRESENTED THE SPECIAL ASPECTS OF THEIR TRAINING, THE STUDENTS ARE ENCOURAGED TO ASK QUESTIONS AND BECOME BETTER ORIENTED ABOUT THE PRACTICE OF MEDICINE IN ITS PRACTICAL, ECONOMIC ASPECTS.

Respectfully submitted,
Edwin B. Jarrett, M.D., *Chairman*
Conrad Acton, M.D., *Secretary*
A. N. Barr, M.D.
J. W. Bird, M.D.
Leslie E. Daugherty, M.D.
H. Vincent Davis, M.D.
A. C. Dick, M.D.
W. H. Fisher, M.D.
David J. Gilmore, M.D.
J. Roy Guyther, M.D.
J. Parran Jarboe, M.D.
Page C. Jett, M.D.
E. Paul Knotts, M.D.
G. A. Kohler, M.D.
Waldo B. Moyers, M.D.
Charles A. Neff, M.D.
William D. Noble, M.D.
M. C. Porterfield, M.D.
J. Oliver Purvis, M.D.
Norman E. Sartorius, Jr., M.D.
Louis R. Schoolman, M.D.
Frank E. Shipley, M.D.
Martin E. Strobel, M.D.
Neil Taylor, M.D.
Eldridge H. Wolff, M.D.
(1956 Committee)

ESSAY CONTEST COMMITTEE

(Appointed by President of the Faculty as authorized by House of Delegates, April 1955.)

Mr. President and Members of the House of Delegates:

One Essay received to date of submitting this report.

Respectfully submitted,
Amos R. Koontz, M.D., *Chairman*

COMMITTEE TO STUDY LICENSURE OF HOMEOPATHIC PHYSICIANS BY HOMEOPATHIC BOARD

(Appointed in 1955, as authorized by House of Delegates, April 1955.)

Mr. President and Members of the House of Delegates:

This Committee met with the Board of Medical Examiners and with a representative from the office of the Attorney General of Maryland. We were advised not to initiate legislation at the 1956 session of the General Assembly which would aim to abolish the Board of Homeopathic Examiners.

Several conferences were held with the Board of Medical Examiners of Maryland and the Board of Medical Examiners of Maryland, Homeopathic, and the Council of the Medical and Chirurgical Faculty.

Future meetings and work along this line are planned.

Respectfully submitted,
Karl F. Mech, M.D., *Chairman*
Lewis P. Gundry, M.D.
Amos R. Koontz, M.D.
Howard M. Bubert, M.D.

COMMITTEE TO COOPERATE WITH BOARD OF MEDICAL EXAMINERS IN REWRITING THE MEDICAL PRACTICE ACT

Mr. President and Members of the House of Delegates:

(As a result of request by the Board of Medical Examiners, appointed August 1954 by the President, upon approval of Executive Committee. The last three were appointed by Board of Medical Examiners.)

Bills were introduced into both the 1955 and 1956 General Assembly of Maryland in an attempt to correct certain deficiencies in the Medical Practice Act.

These Bills were introduced by the Board of Medical Examiners of Maryland. This special committee together with the Legislative Committee and the Board extended their efforts to assure passage. Unfortunately only one section of these changes, that which concerns the fees for examination, has been passed to the present time.

THIS COMMITTEE FEELS THAT SINCE OUR LEGISLATIVE COMMITTEE WORKS CLOSELY WITH THE BOARD OF MEDICAL EXAMINERS CONCERNING THIS TYPE OF LEGISLATION THAT THERE IS NO NEED FOR THIS SPECIAL COMMITTEE AND REQUESTS THAT IT BE DISCHARGED.

Respectfully submitted,
Karl F. Mech, M.D., *Chairman*
Thomas A. Christensen, M.D.
Melvin B. Davis, M.D.
Lewis P. Gundry, M.D.
E. H. Kloman, M.D.
Samuel McLanahan, M.D.

COMMITTEE TO STUDY LIAISON BETWEEN THE MEDICAL PROFESSION AND MARYLAND GENERAL ASSEMBLY

(Appointed in 1955, as authorized by Council.)

Mr. President and Members of the House of Delegates:

This Committee is attempting to develop better liaison between the State Medical Society and the State Legislators. The Committee agrees that this should be done between legislative sessions and not during them. It is from this viewpoint that the Committee is establishing the ground work for continuing contact with individual legislators.

There are no specific recommendations.

Respectfully submitted,

GEORGE H. YEAGER, M.D., *Chairman*
EVERETT S. DIGGS, M.D.
WETHERBEE FORT, M.D.
KARL F. MECH, M.D., Chairman of Legislative Committee
MR. JESSE MARDEN IV
MR. WALTER N. KIRKMAN

COMMITTEE TO STUDY PROBLEMS OF MUTUAL INTEREST TO MEDICAL AND CHIRURGICAL FACULTY AND MARYLAND PHARMACEUTICAL ASSOCIATION

(Appointed in 1955, as authorized by Council April 1955 at the request of the Professional Relations Committee of the Maryland Pharmaceutical Association.)

Mr. President and Members of the House of Delegates:

The Medical-Pharmacy Committee met on one occasion. The discussion was rather general. Several problems were brought up by the Pharmacy representatives concerning prescription refills, Salk vaccine, and the use of Generic names in prescription writing. It was felt that the problems were not within the scope of action of this Committee so that no recommendations were made.

It was suggested that the Committee might be of assistance in serving as a medium between the Medical and Pharmacy groups if necessary, concerning some legislative problems.

Respectfully submitted,

EDWARD F. COTTER, M.D., *Chairman*
MARTIN L. SINGEWALD, M.D.
JAMES R. KARNS, M.D.

MEDICAL ADVISORY COMMITTEE TO THE STATE DEPARTMENT OF HEALTH IN REFERENCE TO POLIO VACCINE IMMUNIZATION PROJECT

(Appointed by the President of the Faculty at request of State Department of Health, December 1954.)

Mr. President and Members of the House of Delegates:

(Report of Committee representing the Medical and Chirurgical Faculty on the State Advisory Committee for Poliomyelitis Vaccine Distribution.)

Early in December 1954 Dr. R. H. Riley, Director of the State Health Department, anticipating the need for an advisory group to assist in planning and administering "The voluntary plan for equitable distribution of poliomyelitis vaccine" asked that three representatives be named from the Medical and Chirurgical Faculty. He further suggested that one of these physicians be named to serve as Chairman of the Committee.

Membership:

Faculty Representatives: Dr. J. Edmund Bradley, Baltimore —Chairman, Dr. Harry D. Bowman, Hagerstown, Dr. William C. Morgan, Salisbury; *Academy of General Practice, Maryland Chapter:* Dr. Lauriston L. Keown, Baltimore, Dr. Robert W. Farr, Chestertown; *Academy of Pediatrics, Maryland Chapter:* Dr. Alexander J. Schaffer, Baltimore; *State Health Department:* Dr. J. Howard Beard, Annapolis, Dr. R. H. Riley (now Dr. Perry F. Prather) ex-officio, Dr. Jean R. Stifler, Dr. Edward Davens, Secretary; *Baltimore City Health Department:* Dr. Huntington Williams; *National Foundation for Infantile Paralysis:* Senator George L. Radcliffe; *State Department of Education:* Dr. Thomas G. Pullen, Jr.; *Parent Teachers Associations:* Mrs. Frederick L. Bull, College Park; *Maryland Pharmaceutical Association:* Mr. Joseph Cohen.

Meetings:

The *first* meeting of the Committee was held on February 11, 1955 in Dr. Riley's office. At this time, which was several months prior to the issuance of the Francis Report, the Committee reviewed the experience of Montgomery County in organizing for mass inoculations of school children.

The background, present status and need for continuing study of the vaccine was summarized by Dr. David Bodian of Johns Hopkins University.

Plans for cooperation with The National Foundation for Infantile Paralysis to carry out a program of injecting all 1st and 2nd grade school children in the public, private and parochial schools of Maryland were outlined by staff of the State Health Department. These plans were, of course, contingent on a subsequent favorable report of the effectiveness and safety of the vaccine. The vaccine was to be supplied by the Foundation.

The Committee also discussed at this time the problem of distribution and use of the small supply of commercial vaccine which was expected to be available to private physicians. In view of the heavy pressures which were certain to develop, it was agreed that priority age-group eligible to receive the vaccine would be selected on the basis of age specific attack rates of paralytic poliomyelitis in Maryland during the past five years.

The *second* meeting of the Committee was held on July 20, 1955. At this time, the principal business was the discussion of Federal legislation on poliomyelitis vaccine, a conference which Dr. Riley had held with Governor McKeldin and the draft of the "State Plan for Poliomyelitis Vaccine Distribution."

Briefly, the Federal law provides funds for vaccine theoretically enough for from 25–30% of all individuals 1–19 years of age and states that "No means test or any other form of discrimination based on ability to pay" will be required. In other words, parents were to have a choice whether to seek the vaccine from a private physician or a public clinic.

ACHROMATIC

ACHROMYCIN*

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obstetric infections

Posner and his colleagues[1] have reported on the use of tetracycline (ACHROMYCIN) in 96 cases of obstetric complications, including unsterile delivery, premature rupture of the membranes, endometritis, parametritis, and other conditions. They conclude that this antibiotic is ideally suited for these uses.

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Every gram of ACHROMYCIN is made in Lederle's own laboratories and offered *only* under the Lederle label—your assurance of quality. It is available in a *complete* line of dosage forms, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection, bolsters the patient's natural defenses, thereby speeds recovery. Especially useful in severe or prolonged illness. Stress formula as suggested by the National Research Council.

SF Capsules, 250 mg.
SF Oral Suspension, 125 mg. per teaspoonful (5 cc.)

For more rapid and complete absorption. Offered only by Lederle!

[1]Posner, A. C., *et al.*; Further Observations on the Use of Tetracycline Hydrochloride in Prophylaxis and Treatment of Obstetric Infections, *Antibiotics Annual* 1954-55, pp. 594-598.

Lederle

LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

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The basic intent of the present program as outlined by the National and State plans of distribution and as directed by Governor McKeldin is that within the limits of the available supply no individual within the eligible ages is to be denied the opportunity of protection.

At this meeting the draft of the "Intra-State Plan for Distribution of Polio Vaccine" was reviewed and approved.

The *third* meeting of the Committee was held on September 21, 1955. A general progress report of the NFIP 1st and 2nd grade school program was made. The need for priority age-groups eligible to receive vaccine was reaffirmed.

The question was also discussed of what corrective action, if any, should be taken when individuals outside the priority groups were vaccinated. It was decided that if the need arose individual instances would be considered by the Committee and referred to the appropriate group—pharmaceutical or medical—for action.

State Plan for Poliomyelitis Vaccine Distribution

The plan as set up by the State Department of Health provides for carrying out the requirements established by the United States Public Health Service in accord with Public Law 377, "Poliomyelitis Vaccination Assistance Act of 1955." The objective of the plan is to assure that poliomyelitis vaccine will be made available to all persons in the priority groups who desire vaccination.

The State Health Department when notified of each new allocation of vaccine reserves 30% for purchase and administration in clinics conducted in the twenty-three counties and Baltimore City. The remaining 70% of each new allocation is released for sale to private physicians.

The Armed Forces have a separate program for eligible dependents of military personnel.

A polio vaccine unit has been set up to receive and analyze copies of all invoices, reports from pharmacies, and reports of vaccinations from private physicians, health departments and others in order to assure equitable distribution and assess progress of vaccinations.

Progress of Inoculations

National Foundation for Infantile Paralysis Program (now completed)

The following are preliminary figures. Final figures must await receipt of data from "make-up" clinics.

1. Total number of children who received first injection last spring	111,499
2. Total number of children with signed requests for first injections last spring	124,437
3. Total number of children receiving first injection following resumption of program (Fall, 1955)	6,894
4. Total number of children receiving first injection spring and fall	118,393
5. Percentage of those requesting last spring who have received first injection	95%
6. Total number of children, receiving second injection (Fall, 1955)	96,712
7. Percentage of those having first injection last spring who had second injection this fall	87%

Routine Continuing Vaccination Program

Up to the first week in January 1956, a total of 200,265 cc. of poliomyelitis vaccine had been shipped to Maryland. This includes commercial, public, and Armed Service supplies.

The State Health Department estimates that total injections in Maryland as of January 1, 1956 are 181,492.

First shots	131,310
Second shots	50,182
Third shots	0
Total	181,492
Private injections:	
First shots	93,194
Second shots	50,182
Public injections:	
First shots	38,116
Second shots	0
Total	181,492

Balance of unused vaccine—18,773.

By and large the vaccine program has gone well in Maryland and it is my view that the effort being made to incorporate as rapidly as possible this new preventive technique into the regular health supervision of all children as a part of the regular practice of medicine and regular routines of the Health Department is indeed wise.

Respectfully submitted,

J. Edmund Bradley, M.D., *Chairman*
William C. Morgan, M.D.
Harry D. Bowman, M.D.

FACT-FINDING COMMITTEE TO INVESTIGATE POSTGRADUATE EDUCATION

(Appointed by the President of the Faculty as authorized by the House of Delegates, September 1954.)

Mr. President and Members of the House of Delegates:

As Chairman of the Fact-Finding Committee to Investigate Postgraduate Education I wish to inform you that very little has been done by the Committee during the past year. It was my sincere hope that by January 1956 an active registry for postgraduate activities in the State would be functioning, but apparently because of lack of help, etc., this has not been accomplished.

On February 1st a dinner meeting was held and attended by Mr. Jesse Marden, Dr. Howard Bubert, Mrs. Carroll and myself. At this meeting it was thought that the office of the Medical and Chirurgical Faculty should obtain complete information regarding postgraduate activities in the State from the secretaries of the medical societies and hospitals of the State in order to make a satisfactory registry. This directory should be sent to the secretaries of the medical societies and directors of the hospitals of the State for bulletin

board postings. Ultimately this directory will be sent to all doctors within the State.

Respectfully submitted,
EDWIN H. STEWART, JR., M.D., *Chairman*
HOWARD M. BUBERT, M.D.
C. LOCKARD CONLEY, M.D.
LAURISTON L. KEOWN, M.D.
BENDER B. KNEISLEY, M.D.
HARRY M. ROBINSON, JR., M.D.

COMMITTEE TO STUDY AVAILABILITY OF PREPAYMENT INSURANCE IN RURAL AREAS

(Appointed by the President of the Faculty as authorized by the House of Delegates, April 1953.)

Mr. President and Members of the House of Delegates:

This Committee was appointed in 1953 and at a recent meeting of this Committee it was felt that the need for this Committee was no longer necessary, inasmuch as prepayment insurance is now available to any individual in the rural areas who may desire same.

Voluntary health insurance has made tremendous strides during the past few years. The latest figures which I have at my disposal show that 101,490,000 of our entire population have coverage in some form. The National Health Insurance Council was created about ten years ago by the various life insurance companies, the purpose of this organization being to sponsor voluntary health insurance plans and to bring about better public relations with our doctors, hospitals and general public. They have done a very fine job in promoting and educating the public on the needs of voluntary health insurance coverage throughout the United States. The Blue Cross and the Blue Shield have also made a wonderful contribution in this respect and now offer coverage to individuals in the counties. Prior to this year they only wrote insurance on groups such as the farm group, volunteer fire departments, church groups and a few other miscellaneous organizations.

Mr. R. H. Dabney informed me that he now has enrolled in the counties 11,000 subscribers in the Blue Cross and 6,000 subscribers in the Blue Shield. However, it is still more advantageous to be enrolled as a group rather than as an individual because of the extra premium charged on the non-group basis.

Last year one of our large insurance companies issued a package policy, which includes life, hospital, sickness, accident and catastrophic coverage. This company will also now issue coverage to individuals, who have physical impairments, on a substandard basis.

DUE TO THE FACT THAT INSURANCE IS NOW MADE AVAILABLE TO INDIVIDUALS IN THE COUNTIES, WE SUGGEST THAT THIS COMMITTEE BE DISMISSED OR AMALGAMATED WITH SOME OTHER COMMITTEE. Our Committee feels that better understanding and relationships in the exchange of information with all insurance companies could be brought about by some committee of this Society working directly with the National Health Insurance Council.

Respectfully submitted,
GEORGE MCLEAN, M.D., *Chairman*
HENRY A. BRIELE, M.D.
NORMAN B. COLE, M.D.
ROBERT P. CONRAD, M.D.
MARIUS P. JOHNSON, M.D.

COMMITTEE TO CONSIDER THE RELATIONSHIP BETWEEN HOSPITALS AND SPECIALTIES AND THE MANNER OF PAYMENT FOR PROFESSIONAL SERVICE

(Appointed in 1951, as authorized by Council February 1951. The last three appointed by Maryland District of Columbia Hospital Association.)

Mr. President and Members of the House of Delegates:

The Committee has had no meetings and has considered no cases during the current year. It is known that an individual and member of the Medical and Chirurgical Faculty requested that a matter be submitted to this Committee but the suggestion was not honored by the other parties to the difference of opinion. It is felt that the Committee should be continued in accordance with the recommendations of the A.M.A. and various other specialty organizations.

Respectfully submitted,
WEBSTER H. BROWN, M.D., *Chairman*
E. HOLLISTER DAVIS, M.D.
HENRY A. WOLLENWEBER, M.D.
A. DOUGAL YOUNG, M.D.
MR. CARROLL D. HILL
MR. PARKER J. MCMILLIN
MR. HARVEY H. WEISS

COMMITTEE TO STUDY REVISION OF THE PRESENT SCHEDULE OF MEDICAL AND SURGICAL FEES OF THE STATE INDUSTRIAL ACCIDENT COMMISSION

(Appointed by the President of the Faculty, at the request of the State Industrial Accident Commission, 1955.)

Mr. President and Members of the House of Delegates:

The Committee to study the Present Medical and Surgical Fees of the State Accident Commission went before the Commission and presented a revised schedule. The Insurance Companies had their Committee to present their objections. After lengthy discussions, it was decided that our Committee should meet with the Insurance Companies' Committee and try to work out a compromise.

Our Committee met with the Insurance Group on April 9th, 1956 and adopted a schedule which is satisfactory to each group.

A final report will be submitted as soon as it is completed.

Respectfully submitted,

CHARLES A. REIFSCHNEIDER, M.D., *Chairman*
HENRY A. BRIELE, M.D.
ROBERT F. CHENOWITH, M.D.
RICHARD G. COBLENTZ, M.D.
CHARLES N. DAVIDSON, M.D.
DONALD B. GROVE, M.D.
HENRY F. ULLRICH, JR., M.D.

COMMITTEE TO MAKE SURVEY OF COMMITTEES

Mr. President and Members of the House of Delegates:

The Council authorized the Secretary, with Dr. W. Houston Toulson as Chairman of the Committee on Constitution and By-Laws, and Dr. George H. Yeager as Past President and Secretary, to survey the Committees of the Faculty and bring back specific recommendations.

This Committee met and submits the following report:

There are three categories of Committee:*

1. *Constitutional Committees*—These appointments are set forth in the Constitution and By-Laws.
2. *Continuing Committees*—All are appointed by the President unless otherwise designated. Many of these Committees are appointed in accordance with specifications that designate the personnel.
3. *Special Committees* are those appointed by the House of Delegates, Council, or Executive Committee, or by the current President, to study a special problem. The duties of some of these committees are completed in a few months, and others require several years. We believe that such committees should have the same personnel. The only alteration or change of personnel would be at the request of the committee as a whole.

We feel that some of these committees should be studied further with a view of combining or discharging one or more of this group. These are as follows:

Committee on Rural Medicine.
Fact-Finding Committee to Investigate Postgraduate Education.
Committee on Public Instruction.
Committee for Better Distribution of Doctors Throughout the State.

At first glance one might feel there is very little correlation between these Committees. However, the Committee on Rural Medicine is working on the premise that its job is primarily to bring to the public in rural areas facts and information that might improve the general health and the general medical information in these areas. It has also in the past worked towards the improvement of the distribution of doctors in providing adequate medical care in rural areas.

The *Committee on Public Instruction* likewise has taken as part of its program the carrying of public instruction in medical matters to all areas of the State by whatever means are available.

The *Fact-Finding Committee to Investigate Postgraduate Education* also has felt that part of its function is the establishment of a registry of educational programs which are available; the integration of educational efforts in the rural areas which would involve both medical and lay educational efforts.

The *Committee for Better Distribution of Doctors Throughout the State* is, of course, involved in the effort to supply adequate medicine to rural areas.

The Committee therefore recommends to the House of Delegates THAT A SMALL COMMITTEE BE APPOINTED BY THE CHAIRMAN OF THE COUNCIL TO STUDY THE INTENT AND ACTIVITIES OF THE COMMITTEE ON RURAL MEDICINE, FACT-FIND IND COMMITTEE TO INVESTIGATE POSTGRADUATE EDUCATION, COMMITTEE ON PUBLIC INSTRUCTION, AND THE COMMITTEE FOR BETTER DISTRIBUTION OF DOCTORS THROUGHOUT THE STATE, AND THAT THIS STUDY COMMITTEE REPORT BACK TO COUNCIL RECOMMENDATIONS CONCERNING THE COMBINATION, CONTINUATION OR DISCHARGE OF THESE COMMITTEES IN ACCORDANCE WITH THAT WHICH WILL BEST ANSWER THE NEEDS OF THE STATE.

THERE ARE SEVERAL COMMITTEES WHICH WE FEEL COULD BE DISCONTINUED: THEY ARE AS FOLLOWS:

Blood Bank Advisory Committee. The Blood Bank Advisory Committee was first developed when blood banks came into being. Except for a very brief period of reactivation two years ago, this Committee is no longer utilized.

Should this need arise, such a Committee can be activated on short notice by the Council or the Executive Committee.

Eugene Fauntleroy Cordell Fund Committee is a Committee whose function is to approve funds to be used for the aid of widows and children of deceased physicians. It has a small sum of money with which to function and it functions at quite rare intervals. The expenditure of such funds could be well turned over to the Finance Committee with authority for its disbursal.

Physiotherapy Committee. The Physiotherapy Committee is no longer necessary. The members of the Board of Physical Therapy Examiners are appointed by the Governor on nomination of the Medical and Chirurgical Faculty. This Board in addition to other duties fulfills the role of the Physiotherapy Committee.

Advisory Committee to the State Health Department. This Committee was first established at a time when the Health Department was subject to a considerable amount of adverse, although unjustifiable, criticism. The conditions no longer exist and our Committee feels that should the need for such an Advisory Committee arise, it could be appointed by the Council.

IT IS THEREFORE RECOMMENDED THAT THE HOUSE OF DELEGATES DISCHARGE THE FOLLOWING COMMITTEES: BLOOD BANK ADVISORY COMMITTEE, EUGENE FAUNTLEROY CORDELL FUND COMMITTEE, PHYSIOTHERAPY COMMITTEE, AD-

* See Supplementary Report following this Report.

VISORY COMMITTEE TO THE STATE HEALTH DEPARTMENT.

Respectfully submitted,
EVERETT S. DIGGS, M.D., *Chairman*
GEORGE H. YEAGER, M.D.
W. HOUSTON TOULSON, M.D.

Supplementary Report of Committee to Survey Committees*

EVERETT S. DIGGS, M.D.

(Method of Appointing Committees)

Committees Elected by the House of Delegates

(As set forth in Constitution and By-Laws)

Committee on Scientific Work and Arrangements
Library Committee
Finney Fund Committee

Appointed by Council

Curator
Maryland State Medical Journal
Editor
Editorial Board

Constitutional Committees

(These Appointments are set forth in the Constitution and By-Laws)

Committee on Constitution and By-Laws

Executive Committee of the Council
(Chairman of the Council, President, Secretary and Treasurer)

Finance Committee

(Five members, namely, the Chairman of the Council, the Treasurer, the Secretary, and two members of the Faculty appointed by the Chairman of the Council.)

The House Committee

(Executive Committee plus the Chairman of Library Committee.)

Professional Conduct Committee

(Five living immediate Past Presidents and Chairman of the Council, with the Senior Past President as Chairman, and each Past President to serve for five years on Committee.)

Resolutions Committee

(Five members to be appointed annually by the President who shall also designate the Chairman.)

Budget Committee

(Appointed on authority of Council by its Chairman.)

Continuing Committees

(All are appointed by the President unless otherwise designated. Many of these Committees are appointed in accordance with specifications that designate the personnel.)

Committee to Cooperate with American Medical Education Foundation
Army Medical Library Committee
Blood Bank Advisory Committee
Eugene Fauntleroy Cordell Fund Committee
Committee on Diabetes
Geriatrics Committee
Committee on Industrial Health
Legislative Committee
Maternal and Child Welfare Committee
Joint Committee with Bar Associations on Medicolegal Problems
Memoir Committee
Mental Hygiene Committee
Committee on National Emergency Medical Service
Committee for the Study of Pelvic Cancer (With special structure)
Physiotherapy Committee
Committee on Public Instruction
Committee on Rural Medicine

Advisory Committee to State Health Department

(The Committee to consist of the President, the President-elect, two Past Presidents, the Secretary and four general practitioners, appointed by the President, of which one represents the Maryland Academy of General Practice.) (Presidential with specific directions)

Advisory Committee to the State Accident Fund
Tuberculosis Committee
Committee on Veterans' Medical Care
Advisory Committee to the Woman's Auxiliary

Committee for Better Distribution of Doctors Throughout the State

(Appointed by the President of the Faculty as authorized by the House of Delegates, September 1952)

Committee to Study Problems of Mutual Interest to the Medical and Chirurgical Faculty and the Maryland Pharmaceutical Association

(Appointed in 1955, as authorized by Council April 1955 at the request of the Professional Relations Committee of the Maryland Pharmaceutical Association.)

Special Committees

(Appointed by the House of Delegates, Council, or Executive Committee, or by the current President, to study a special problem. The duties of some of these Committees are completed in a few months, and others require several years. We believe that such committees should have the same personnel. The only alteration or change of personnel would be at the request of the committee as a whole.)

* This part of the report was distributed to the House of Delegates at its meeting on Friday, May 4, 1956.

Committee to Study the Problem of Accreditation of Hospitals

(Appointed by the President of the Faculty as authorized by the House of Delegates.)

Committee to Confer with Blue Cross and Blue Shield in Regard to Radiological Section Resolution

(Appointed by the President of the Faculty as authorized by House of Delegates, April 1954.)

Essay Contest Committee (American Association of Physicians and Surgeons)

(Appointed by President of the Faculty as authorized by House of Delegates, April 1955.)

Committee to Study the Licensure of Homeopathic Physicians by the Homeopathic Board

(Appointed in 1955, as authorized by House of Delegates, April 1955.)

Committee to Investigate the Malpractice Insurance Problem.

(Appointed September 1955, as authorized by Council, September, 1955.)

Committee to Meet with Board of Medical Examiners Regarding Annual Registration of Physicians

(Appointed by President, July, 1954, as a result of action of House of Delegates in April 1954.)

Committee to Study Liaison Between the Medical Profession and Maryland General Assembly

(Appointed in 1955, as authorized by Council.)

Committee to Cooperate with the Board of Medical Examiners in Re-writing the Medical Practice Act

(As a result of request by the Board of Medical Examiners, appointed August 1954 by the President, upon approval of Executive Committee. The last three were appointed by Board of Medical Examiners.)

Medical Advisory Committee to State Department of Health in Reference to Polio Vaccine Immunization Project

(Appointed by the President of the Faculty at request of State Department of Health, December 1954.)

Fact-Finding Committee to Investigate Postgraduate Education

(Appointed by the President of the Faculty as authorized by the House of Delegates, September 1954.) (For specific study.)

Committee Regarding Preceptorship for Medical Students

(Appointed in 1956, as authorized by the Council, December 1955. Reported to Council, March 1956, and discharged.)

Committee to Study Availability of Prepayment Insurance in Rural Areas

(Appointed by the President of the Faculty as authorized by the House of Delegates, April 1953.)

Committee to Consider the Relationship Between Hospitals and Specialties and the Manner of Payment for Professional Services

(Appointed in 1951, as authorized by Council February 1951. The last three appointed by Maryland-District of Columbia Hospital Association.)

Committee to Study a Revision of the Present Schedule of Medical and Surgical Fees of the State Industrial Accident Commission

(Appointed by the President of the Faculty, at the request of the State Industrial Accident Commission, 1955.)

Committee to Make Survey of Committees

(Appointed in 1955, as authorized by Council, December 1955.)

Specially Appointed

Maryland Advisory Committee to Selective Service

POISON CONTROL CENTERS*

Important Announcement

By
Maryland Chapter—American Academy of Pediatrics
THOMAS A. CHRISTENSEN, M.D.

The American Academy of Pediatrics through its Accident Prevention Committee has been stimulating the development of Poison Control Centers in teaching hospitals throughout the country. The Maryland Chapter, through its Accident Prevention Committee and Poison Control Center Committee, is establishing two Poison Control Centers, one at Johns Hopkins Hospital and the other at University of Maryland Hospital. These centers have been established under the auspices of the Department of Pediatrics in the respective institutions. Dr. Samuel Bessman, Associate Professor of Pediatrics, will be in charge of the University of Maryland Hospital Center and Dr. Thomas E. Reichelderfer, Instructor of Pediatrics, will be in charge of the Johns Hopkins Hospital Center. The Poison Control Committee of the American Academy of Pediatrics has formulated plans for the establishment and methods of functioning of these Centers. This committee will be happy to supply information to any other hospital within the State which desires to establish a similar program. The committee is at all times available to such a unit for consultation. A set of reference texts, pamphlets, and reprints pertinent to poisons has been made available to each Center by the committee. The technical consultation is readily available through the assistance of Henry C. Freimuth, Ph.D., John Krantz, M.D., and Gilbert H. Mudge, M.D.

The Home Accident Prevention Unit of the Maryland State Department of Health has agreed to tabulate statistical data on poisonings, and from time to time, when a par-

* Presented to the 218th Meeting of the House of Delegates, May 4, 1956.

ticular poison seems to become prominent, issue communications to physicians and lay groups. When new poisons are encountered, it will with the assistance of the Poison Control Center and consultants, provide the latest information available on these substances.

The Poison Control Officer in each hospital will maintain a standard list of equipment and antidotes for emergency use, plus authoritative reference material on poisons. Any physician may telephone for information. *Such calls should be made either to University Hospital (LExington 9-0320) or to Johns Hopkins Hospital (ORleans 5-5500) and ask for "Poison Control Center."* When indicated the case may be brought into the Center for treatment. The University Center is located in the University Hospital, Wing 5-D. The one at Johns Hopkins Hospital is set up in the Department of Pediatrics.

A brief form summarizing the results will be filed at the Center for follow-up and for determination of the most effective treatment and antidotes. A double post card will be mailed to the referring physician to determine the outcome of treatment. This data will then be sent to the Home Accident Prevention Unit for summation and analysis. The Poison Control Officer will be responsible for teaching all medical students, house staff, nurses, and others involved, especially those persons answering the calls at the Poison Control Center.

During the past few years in several parts of the country a number of physicians, public health workers and others closely associated with problems of poisoning, particularly in children, have become interested in ways and means of controlling accidental poisoning. However, it was not until 1950 when the American Academy of Pediatrics Committee on Accident Prevention made a survey of the nature of accidents treated by pediatricians that nation-wide attention was focused on the problem of accidental poisoning in children. The pediatricians responding to the survey indicated that fully half of the patients they treated for accidents resulted from poisoning by household substances.

The study and control of these accidents became an important part of the program of the committee. In order to work out the best methods of handling this problem a pilot project was begun in Chicago under the auspices of the Illinois Chapter of the American Academy of Pediatrics. The project was established as a poison control Center, involving the cooperation of the heads of pediatric service in the major hospitals, the Health Department, State Toxicological Laboratory and other state and local agencies. The Chicago Center which began operating in November of 1953 included information, treatment and prevention in its objectives and procedures and was the first of its type in the country. Using a looseleaf outline guide for the treatment of poisoning developed by Dr. Edward Press who was chairman of the Chicago Center at the time and with the support and through the framework of the Accident Prevention Committee of the Academy of Pediatrics several other cities throughout the country developed similar poisoning control centers. By the spring of 1955 there were centers in actual operation or in advanced stages of development in at least 11 cities in the United States. Each of these centers was organized and operated on an individual basis with its organizational pattern and procedures adapted to fit the local situation. However, all of them were loosely related to the Subcommittee on Poisoning of the Academy's Prevention Committee.

The institutions and individuals cooperating to provide this important service in Maryland are listed below. All physicians are cordially invited to make maximum use of the services of these centers.

Maryland Chapter American Academy of Pediatrics

University of Maryland Hospital, Poison Control Center (24 hour service), Telephone: LExington 9-0320

Department of Pediatrics

SAMUEL BESSMAN, M.D., Associate Professor of Pediatrics, Poison Control Coordinator

Johns Hopkins Hospital—Poison Control Center; Telephone ORleans 5-5500 (24 hour service)

Department of Pediatrics

THOMAS E. REICHELDERFER, M.D., Instructor of Pediatrics, Poison Control Coordinator

Accident Prevention Committee

Poison Control Center Committee

JOHN A. ASKIN, M.D., Chairman
SAMUEL BESSMAN, M.D.
THOMAS A. CHRISTENSEN, M.D.
EDWARD DAVENS, M.D.
THOMAS E. REICHELDERFER, M.D.

Consultants to Committee

HENRY C. FREIMUTH, Ph.D., Toxicologist, Maryland Dept. of Post Mortem Examiners

JOHN KRANTZ, M.D., Professor of Pharmacology, Univ. of Maryland School of Medicine

GILBERT H. MUDGE, M.D., Professor of Pharmacology, Johns Hop. Univ. School of Medicine.

Home Accident Prevention Unit

Maryland State Department of Health, MR. J. CHARLES JUDGE, Chief

OFFICERS, COUNCILS, SPECIAL COMMITTEES, ETC.* 1956

(Reprinted from Annual Meeting Hand Book, 1956)

OFFICERS

President—William H. F. Warthen, Towson
Vice-President—Beverley C. Compton, Baltimore; Ernest F. Poole, Hagerstown; Henry A. Briele, Salisbury
Treasurer—Wetherbee Fort, Baltimore
Secretary—Everett S. Diggs, Baltimore

COUNCILORS

	Term Expires
Warfield M. Firor, *Chairman*, Baltimore	1957
Whitmer B. Firor, *Vice-Chairman*, Baltimore	1957
A. Talbott Brice, Jefferson	1956
Harry C. Hull, Baltimore	1956
W. Oliver McLane, Jr., Frostburg	1956
W. Glenn Speicher, Westminster	1956
Leo Brady, Baltimore	1957
Thomas A. Christensen, College Park	1957
Clewell Howell, Towson	1957
Ross L. McLean, Baltimore	1957
Norman E. Sartorius, Jr., Pocomoke City	1957
Howard M. Bubert, Baltimore	1958
David J. Gilmore, Salisbury	1958
Albert E. Goldstein, Baltimore	1958
Ralph G. Hills, Baltimore	1958
William H. F. Warthen, *President*, Baltimore	1956
George H. Yeager, *Past-President*, Baltimore	1955
Wetherbee Fort, *Treasurer*, Baltimore	1956
Everett S. Diggs, *Secretary*, Baltimore	1956
President-elect	1957
Louis Krause, *Chairman of Library Committee*, Baltimore	1960
Warde B. Allan, *A.M.A. Delegate*, Baltimore	1956
Robert vanL. Campbell, *A.M.A. Delegate*, Hagerstown	1957
W. Houston Toulson, *Chairman, Committee on Constitution and By-Laws*, Baltimore	1956

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

	Term Expires
Delegate—Warde B. Allan, Baltimore	1956
Alternate—H. Hanford Hopkins, Baltimore (Appointed by Council to serve until meeting of House of Delegates, May 1956)	
Delegate—Robert vanL. Campbell, Hagerstown	1957
Alternate—William B. Long, Salisbury	1957

MEMBERS OF THE BOARD OF MEDICAL EXAMINERS

	† Term Expires
Samuel McLanahan, *President*, Baltimore	1956
Lewis P. Gundry, *Secretary-Treasurer*, Baltimore	1958
John E. Legge, Baltimore	1956
Henry T. Collenberg, Baltimore	1957
Norman E. Sartorius, Jr., Pocomoke City	1957
Wylie M. Faw, Cumberland	1958
John H. Hornbaker, Hagerstown	1959
Frank K. Morris, Baltimore	1959

COMMITTEES

Elected by the House of Delegates

Committee on Scientific Work and Arrangements

Edmond J. McDonnell, *Chairman*, Baltimore
Norman R. Freeman, Jr., Baltimore
Sidney Novenstein, Funkstown
Everett S. Diggs, *Secretary*, Baltimore (In conformity with Constitution and By-Laws.)

Library Committee

	Term Expires
Louis Krause, *Chairman*, Baltimore	1960
A. Austin Pearre, Frederick	1956
J. Roy Guyther, Mechanicsville	1957
E. T. Lisansky, Baltimore	1958
Lester A. Wall, Jr., Baltimore	1959
Marion W. McCrea, D.D.S.	

Finney Fund Committee

	Term Expires
Louis P. Hamburger, *Senior Member*, Baltimore	1956
I. Ridgeway Trimble, Baltimore	1957
Herbert E. Wilgis, Baltimore	1958
Henry J. L. Marriott, Baltimore	1959
George G. Finney, Baltimore	1960

Appointed by Council

Curator
J. Albert Chatard‡

The Maryland State Medical Journal

George H. Yeager, *Editor*, Baltimore

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* Committees appointed by the President, Dr. William H. F. Warthen, published in Vol. 5, No. 1, January 1956, Maryland State Medical Journal.

In this issue, the names of members of Committees are printed after each report.

† Under the State Law, terms of office of all members of Board shall begin the first Tuesday in June of the year in which they are elected.

‡ Deceased.

Editorial Board

LESLIE E. DAUGHERTY, Cumberland
HUGH J. JEWETT, Baltimore
WILLIAM B. LONG, Salisbury
EMIL NOVAK, Baltimore
JOHN A. WAGNER, Baltimore
A. EARL WALKER, Baltimore
MR. JESSE MARDEN IV, *Business Manager*, Baltimore

AS PROVIDED IN THE CONSTITUTION AND BY-LAWS

Committee on Constitution and By-Laws

W. HOUSTON TOULSON, *Chairman*, Baltimore
E. COWLES ANDRUS, Baltimore
CHARLES R. AUSTRIAN, Baltimore
THURSTON HARRISON, Easton
DONALD HOOKER, Baltimore
WILLIAM S. LOVE, Baltimore
ALBERT RICHARD MILAN, Baltimore
JOHN D. YOUNG, JR., Baltimore

Executive Committee of the Council

(Chairman of the Council, President, Secretary and Treasurer.)

WARFIELD M. FIROR, *Chairman of Council*, Baltimore
WILLIAM H. F. WARTHEN, *President*, Towson
EVERETT, S. DIGGS, *Secretary*, Baltimore
WETHERBEE FORT, *Treasurer*, Baltimore

Finance Committee

(Five members, namely, the Chairman of the Council, the Treasurer, the Secretary, and two members of the Faculty appointed by the Chairman of the Council.)

WETHERBEE FORT, *Treasurer, Chairman*, Baltimore
CHARLES R. AUSTRIAN, Baltimore
EVERETT S. DIGGS, *Secretary*, Baltimore
WARFIELD M. FIROR, *Chairman of Council*, Baltimore
R. WALTER GRAHAM, JR., Baltimore

The House Committee

(Executive Committee plus the Chairman of the Library Committee.)
WARFIELD M. FIROR, *Chairman of Council*, Baltimore
WILLIAM H. F. WARTHEN, *President*, Towson
EVERETT S. DIGGS, *Secretary*, Baltimore
WETHERBEE FORT, *Treasurer*, Baltimore
LOUIS KRAUSE, *Chairman Library Committee*, Baltimore

Professional Conduct Committee

(Five living immediate Past Presidents and Chairman of the Council, with the Senior Past President as Chairman, and each Past President to serve for five years on Committee.)

WALTER D. WISE (*President in 1951*), *Chairman*, Baltimore
ALAN M. CHESNEY (*President in 1952*), Baltimore
MAURICE C. PINCOFFS (*President in 1953*), Baltimore
BENDER B. KNEISLEY (*President in 1954*), Hagerstown
GEORGE H. YEAGER (*President in 1955*), Baltimore
WARFIELD M. FIROR (*Chairman of Council in 1956*), Baltimore

Resolutions Committee

(Five members to be appointed annually by the President of the Medical and Chirurgical Faculty, who shall also designate the Chairman.)

ROBERT VANL. CAMPBELL, *Chairman*, Hagerstown
ERNEST I. CORNBROOKS, JR., Baltimore
MELVIN B. DAVIS, Dundalk
ROBERT W. FARR, Chestertown
JOHN D. YOUNG, JR., Baltimore

Budget Committee

(Appointed on authority of Council by its Chairman.)

E. COWLES ANDRUS, *Chairman*, Baltimore
BENDER B. KNEISLEY, Hagerstown
RICHARD C. DODSON, Baltimore
WETHERBEE FORT, Baltimore
NORMAN E. SARTORIUS, JR., Pocomoke City

COMMITTEES

The names of the members of the Committees follow at the end of each report.

The following Committees are listed as the names of the members are not given elsewhere in these Transactions:

Committee to Investigate the Malpractice Insurance Problem

(Appointed September 1955, as authorized by Council, September 1955.)

EDWARD S. STAFFORD, *Chairman*, Baltimore
WILLIAM E. GROSE, Baltimore

Committee to Meet with Board of Medical Examiners Regarding Annual Registration of Physicians

(Appointed by President, July 1954, as a result of action of House of Delegates in April 1954.)

EVERETT S. DIGGS, *Chairman*, Baltimore
ERNEST F. POOLE, Hagerstown
MR. WALTER N. KIRKMAN, Baltimore

OFFICERS, DELEGATES, MEETING TIME, ETC., OF COMPONENT MEDICAL SOCIETIES, 1956

(Reprinted from Annual Meeting Program, 1956)

ALLEGANY-GARRETT COUNTY. *President*—W. Alfred Van-Ormer, Cumberland; *Vice-President*—Benedict Skitarelic, Cumberland; *Secretary*—Leslie E. Daugherty, Cumberland; *Treasurer*—Leo H. Ley, Jr., Cumberland; *Delegates*—James T. Johnson, Jr., Cumberland and Hilda Jane Walters, Frostburg; *Alternate Delegates*—Frank T. Harrat, Frostburg and Leland B. Ranson, Cumberland; *Journal Representative*—Leslie E. Daugherty, Cumberland; *Meetings*—On call

ANNE ARUNDEL COUNTY. *President*—Philip Briscoe, Annapolis; *Vice-President*—Gustav H. Faubert, Glen Burnie; *Secretary-Treasurer*—J. Howard Beard, Annapolis; *Delegate*—Randall McLaughlin, Pasadena; *Alternate Delegate*—Merton T. Waite, Annapolis; *Journal Representative*—Stuart Christhilf, Jr., Annapolis; *Meetings*—Four times a year.

BALTIMORE CITY. *President*—Grant E. Ward; *First Vice-President*—Francis J. Geraghty; *Second Vice-President*—Whitmer B. Firor; *Secretary*—John N. Classen; *Treasurer*—Robert C. Kimberly; *Journal Representative*—Conrad Acton; *Representatives to the Executive Board*—Houston S. Everett (1956–1957), William L. Garlick (1956–1957), Theodore H. Morrison (1956–1957), Amos R. Koontz (1956), C. Holmes Boyd (1955–1956), Louis Krause (1955–1956)

1955–1956

Delegates	*Alternates*
Helen Bowie	Joseph B. Workman
C. Lockard Conley	Frank W. Davis, Jr.
Ernest I. Cornbrooks, Jr.	Theodore Kardash
Palmer H. Futcher	Ernest S. Cross, Jr.
R. Donald Jandorf	Ernest C. Brown, Jr.
Richard F. Kieffer, Jr.	William G. Speed
Ephraim T. Lisansky	D. McClelland Dixon
Robert E. Mason	John J. Tansey
James P. Miller	Edward H. Richardson, Jr.
Samuel Morrison	David R. Will
E. Roderick Shipley	John L. Peck
John H. Trescher	Francis W. Gillis
John D. Young, Jr.	Alan C. Woods, Jr.
Ralph J. Young	James N. McCosh

1956–1957

Robert C. Abrams	Albert R. Milan
Walter A. Anderson	Raymond C. V. Robinson
Philibert Artigiani	William D. Lynn
Walter B. Buck	John W. Chambers
William E. Gilmore	Robert M. N. Crosby
Jacob C. Handelsman	Perry Futterman
I. Bradshaw Higgins	Ruth W. Baldwin
Robert W. Johnson, III	Mary L. Hayleck
Henry J. L. Marriott	Norman R. Freeman, Jr.
Nathan E. Needle	Thomas E. Van Metre, Jr.
Samuel T. R. Revell, Jr.	Milton B. Kress
Martin L. Singewald	William F. Pearce
Douglas H. Stone	J. Elliot Levi
J. Frank Supplee, III	James J. Gerlach

Meetings—First Friday of each month, October through March

BALTIMORE COUNTY. *President*—Louis Z. Dalmau, Pikesville; *Vice-President*—William A. Pillsbury, Jr., Timonium; *Secretary-Treasurer*—Charles Lee Randol, Pikesville; *Delegates*—Melvin B. Davis, Dundalk, Charles F. O'Donnell, Towson, and Martin E. Strobel, Reisterstown; *Alternate Delegates*—David H. Andrew, Dundalk, Paul H. Royse, Pikesville, and Charles H. Williams, Pikesville; *Journal Representative*—Donald L. Somerville, Towson; *Meetings*—Third Wednesday of each month

CALVERT COUNTY. *President*—Roberto deVillarreal, Prince Frederick; *Vice-President*—Hugh W. Ward, Owings; *Secretary-Treasurer*—George J. Weems, Huntingtown; *Delegate*—Page C. Jett, Prince Frederick; *Alternate Delegate*—Hugh W. Ward, Owings; *Journal Representative*—Page C. Jett, Prince Frederick; *Meetings*—On call

CAROLINE COUNTY. *President*—Robert Wright, Greensboro; *Vice-President*—Dawson O. George, Denton; *Secretary-Treasurer*—Edwin G. Riley, Denton; *Delegate*—Charles H. Winnacott, Ridgely; *Alternate Delegate*—Robert Kingsbury, Federalsburg; *Journal Representative*—Robert Wright, Greensboro; *Meetings*—On call

CARROLL COUNTY. *President*—G. Allen Moulton, Jr., Westminister; *Vice-President*—Martin Gross, Sykesville; *Secretary-Treasurer*—William Culwell, Mt. Airy; *Delegate*—R. S. McVaugh, Taneytown; *Alternate Delegate*—Merritt Robertson, New Windsor; *Journal Representative*—Julius Chepko, Westminister; *Meetings*—First Wednesday of each month

CECIL COUNTY. *President*—Wallace Obenshain, Cecilton; *Vice-President*—H. Vincent Davis, Chesapeake City; *Secretary-Treasurer*—Klaus Huebner, North East; *Delegate*—George J. Kreis, Jr., Elkton; *Alternate Delegate*—S. Ralph Andrews, Elkton; *Journal Representative*—Milford H. Sprecher, Elkton; *Meetings*—Monthly, second Tuesday of each month

CHARLES COUNTY. *President*—Harry R. Coburn, Bryantown; *Vice-President*—Frederick M. Johnson, La Plata; *Secretary-Treasurer*—J. Parran Jarboe, La Plata; *Delegate*—Edward J. Edelen, La Plata; *Alternate Delegate*—William J. Kurz, La Plata; *Journal Representative*—J. Parran Jarboe, La Plata; *Meetings*—Second Thursday of each month

DORCHESTER COUNTY. *President*—George Currier, Cambridge; *Vice-President*—Wilbur Bauman, Cambridge;

Secretary-Treasurer—Lawrence Maryanov, Cambridge; *Delegate*—Frederick A. Miller, Cambridge; *Alternate Delegate*—Wm. H. Hanks, Cambridge; *Journal Representative*—Alfred R. Maryanov, Cambridge; *Meetings*—Once monthly

FREDERICK COUNTY. *President*—Norvell Belt, Frederick; *Vice-President*—James B. Thomas, Frederick; *Secretary*—Albert M. Powell, Jr., Frederick; *Treasurer*—John M. Culler, Frederick; *Delegate*—Louis R. Schoolman, Frederick; *Alternate Delegate*—Henry V. Chase, Frederick; *Journal Representative*—Robert J. Furie, Frederick; *Meetings*—Third Tuesday of each month

HARFORD COUNTY. *President*—Paul Stonesifer, Bel Air; *Vice-President*—Charles W. Stewart, Jr., Edgewood; *Secretary-Treasurer*—Barry J. Plunkett, Jr., Aberdeen; *Delegate*—J. Ralph Horky, Churchville; *Alternate Delegate*—Philip W. Heuman, Bel Air; *Journal Representative*—Barry J. Plunkett, Jr., Aberdeen; *Meetings*—Third Wednesday or Thursday—10 meetings a year

HOWARD COUNTY. *President*—George E. Groleau, Elkridge; *Vice-President*—Charles S. Whitaker, Clarksville; *Secretary-Treasurer*—Theodore R. Shrop, Ellicott City; *Delegate*—C. S. Whitaker, Clarksville; *Alternate Delegate*—Theodore R. Shrop, Ellicott City; *Journal Representative*—Theodore R. Shrop, Ellicott City; *Meetings*—Fourth Friday, except July

KENT COUNTY. *President*—A. C. Dick, Chestertown; *Secretary-Treasurer*—Florence D. Joyce, Worton; *Delegate*—Robert W. Farr, Chestertown; *Alternate Delegate*—Willard F. Smith, Rock Hall; *Journal Representative*—Florence D. Joyce, Worton; *Meetings*—On call

MONTGOMERY COUNTY. *President*—Robert A. Bier, Silver Spring; *Vice-President*—Merrill M. Cross, Silver Spring; *Secretary*—Charles I. Warfield, Silver Spring; *Treasurer*—Stephen N. Jones, Rockville; *Delegates*—M. McKendree Boyer, Damascus, Read N. Calvert, Silver Spring, Jacob W. Bird, Sandy Spring, and John G. Ball, Bethesda; *Alternate Delegates*—William S. Murphy, Rockville, John O. Robben, Silver Spring, Merrill M. Cross, Silver Spring, and Austin B. Rohrbaugh, Jr., Chevy Chase; *Journal Representatives*—James P. McCarrick, Rockville, and Maynard I. Cohen, Silver Spring; *Meetings*—Third Tuesday of each month, January through May.

PRINCE GEORGE'S COUNTY. *President*—William B. Hagan, Mt. Rainier; *Vice-President*—Hans Wodak, Greenbelt; *Corresponding Secretary*—John Kehoe, Cheverly; *Recording Secretary*—Lloyd W. Hughes, College Park; *Treasurer*—Frederick L. Musser, Cheverly; *Delegates*—Wolcott Etienne, College Park, and Waldo B. Moyers, Hyattsville; *Alternate Delegates*—John S. Haught, Mt. Rainier, and Benjamin S. Miller, Mt. Rainier; *Journal Representative*—Hans Wodak, Greenbelt; *Meetings*—First Tuesday of each month

QUEEN ANNE'S COUNTY. *President*—C. Rodney Layton, Centreville; *Secretary-Treasurer*—Caroline H. Callison, Centreville; *Delegate*—I. G. Hoyt, Queenstown; *Alternate Delegate*—H. F. McPherson, Centreville; *Journal Representative*—W. H. Fisher, Centreville; *Meetings*—Quarterly

ST. MARY'S COUNTY. *President*—Wm. D. Boyd, Leonardtown; *Vice-President*—Joseph E. Gill, Leonardtown; *Secretary-Treasurer*—J. Roy Guyther, Mechanicsville; *Delegate*—Julian S. Lane, Lexington Park; *Alternate Delegate*—Wm. H. Patrick, Lexington Park; *Journal Representative*—J. Roy Guyther, Mechanicsville; *Meetings*—Second Wednesday every month

SOMERSET COUNTY. *President*—C. G. Rawley, Crisfield; *Secretary-Treasurer*—Robert H. Johnson, Princess Anne; *Delegate*—George C. Coulbourn, Marion Station; *Alternate Delegate*—C. G. Rawley, Crisfield; *Journal Representative*—A. N. Barr, Crisfield; *Meetings*—On call

TALBOT COUNTY. *President*—W. N. Palmer, Easton; *1st Vice-President*—P. Evans Cox, Easton; *2nd Vice-President*—A. B. Cecil, Jr., Easton; *Secretary-Treasurer*—Louis S. Welty, Easton; *Delegate*—Thurston Harrison, Easton; *Alternate Delegate*—Howard F. Kinnamon, Easton; *Journal Representative*—Louis S. Welty, Easton; *Meetings*—Four times a year

WASHINGTON COUNTY. *President*—L. A. Hoffman, Hagerstown; *Vice-President*—W. H. Shealy, Sharpsburg; *Secretary-Treasurer*—Ernest F. Poole, Hagerstown; *Delegates*—William T. Layman, Hagerstown, and G. W. LeVan, Boonsboro; *Alternate Delegates*—John J. Dobbie, Hagerstown, and John A. Moran, Hagerstown; *Journal Representative*—Robert vanLieu Campbell, Hagerstown; *Meetings*—January, April, July, October

WICOMICO COUNTY. *President*—Frank E. Poole, Salisbury; *Vice-President*—John M. Bloxom, III, Salisbury; *Secretary-Treasurer*—William H. Dumeyer, Salisbury; *Delegate*—Stedman W. Smith, Salisbury; *Alternate Delegate*—Osborne D. Christensen, Salisbury; *Journal Representative*—William H. Dumeyer, Salisbury; *Meetings*—Second Monday of each month

WORCESTER COUNTY. *President*—F. S. Waesche, Snow Hill; *Vice-President*—Charles W. Trader, Pocomoke City; *Secretary-Treasurer*—Paul Cohen, Snow Hill; *Delegate*—Norman E. Sartorius, Sr., Pocomoke City; *Alternate Representative*—Robert LaMar, Snow Hill; *Journal Representative*—Paul Cohen, Snow Hill; *Meetings*—Fourth Wednesday, January, April, July, October

COMPLETION OF 1956 TRANSACTIONS

EDITORIAL

GLAUCOMA

LESLIE E. DAUGHERTY, M.D.

Increased intraocular tension in time gradually leads to a hardening of the eyeball. It is often mistaken for a cataract, because of a gradual loss of sight.

Many persons have waited all too long, to have a supposed cataract removed, because of failing sight, when the disease was really glaucoma.

Modern conditions now recognize glaucoma as either of a narrow angle type, or an open angle type. Statistics reveal, there are 30,000 persons in the United States alone, who are totally blind from glaucoma and that there are from 800,000 to a million, who have unrecognized glaucoma. One blind person on an average costs the American taxpayer $40,000, during his or her lifetime. So, it is economically sound to get glaucoma eyes under treatment early.

When should a person be examined for glaucoma?

Undoubtedly, at every eye examination, glaucoma should be considered as a possibility. Second, if a person is wearing glasses that must be changed frequently, a most likely cause is glaucoma.

Narrow angle glaucoma is primarily surgical and every physician can, or should recognize it. First of all, the pain and appearance of the eye is almost pathognomonic, until a diagnosis is properly made. If questionable treatment is instituted, sight recedes and most expert management is desirable immediately.

The narrow angle glucoma has a steamy cornea, its layers are edematous. The circumcornea area is congested and there is severe pain, unrelieved except by morphia, miotics and diamox; or by surgery, such as a peripheral iridectomy. Sometimes, all four methods of treatment are necessary to accomplish the desired results. Peripheral iridectomy is nonmutilating and practically free from complications and brings immediate relief in most cases. Thus, a cure is accomplished, by providing an exit for the aqueous from the posterior chamber through the trabecular spaces of fontana and canal of Schlemm. If this is done within 36 hours, at the most, after the onset, or before the iris becomes adherent to the cornea; the eye will most likely be saved. Medication usually lowers the pressure enough, for safe surgery. Diamox inhibits the formation of aqueous, thereby relieving the pressure in the anterior chamber.

Intraocular pressure soon goes up, when the angle is closed, or almost closed. Any pressure of 25 (Schiotz) is questionable glaucoma, until provocative tests rule out the disease. Gonioscopy clinches the diagnosis at all times.

In the open angle glaucoma, sometimes called wide angle glaucoma, the condition is quite different and medication usually suffices to keep it under control. Over long periods of time, the eye may suffer from the continued increase in pressure and the fields be distorted, as revealed by the perimeter and tangent screen tests. In open angle glaucoma, it is necessary to prevent if at all possible, any narrowing of the angle of the anterior chamber; since the angle is already anatomically deficient. That is, there is insufficient drainage through the trabeculum, to begin with. By keeping the pupil in a miotic condition, usually

there is enough escape of aqueous, to maintain a well compensated eye. Should this fail, a filtering type of operation is the answer. While the gradual loss of sight is not always arrested by surgery and even though the eye may go on to blindness, one should not hesitate to recommend surgery before the eye is too severely damaged. Some eyes have been carried along for years, without surgery; leading many physicians to the conclusion, that perhaps all eyes could be saved by medicine.

Constant supervision by an Ophthalmologist, is the only safe way to preserve sight; if that is possible.

How can the family physician determine whether the patient has glaucoma, or not?

Use of the Tonometer, is no more difficult than the sphygmomanometer and every physician doing office work, should have a Schiotz tonometer ready at all times. By placing a drop of one-half per cent pontocaine into the conjunctival sac of both eyes, a tonometric reading can be made in one minute. This will invariably make a differential diagnosis between iritis and glaucoma.

In open angle glaucoma, the situation is one in which the fluid cannot leave the anterior chamber because of anatomical deficiency. Increasing the fluid intake by mouth, increases the production of aqueous; so if the patient abstains from fluids for 8 hours, or from midnight until morning, the physician can make the tonometric test and record it and then have the patient drink 1,000 cubic centimeters of water and at the end of fifteen minutes, he repeats the tonometric test. By repeating the test every fifteen minutes, for the next 45 minutes, any rise in the intraocular pressure will be recorded and if a 10 millimeter increase is found, the patient most likely has open angle glaucoma and may be diagnosed by the Ophthalmologist, at a subsequent examination.

Summarizing then:

Glaucoma is a common disease. Unrecognized, it always leads to blindness. In the narrow angle type, congestion, high tension and pain, are the distinguishing features and surgery is the treatment. In open angle type, pain and congestion are not the rule and treatment is usually satisfactory with medicine.

Recognition is possible, by the family physician.

Treatment may well be left to the Ophthalmologist.

7 Washington Street
Cumberland, Maryland

CIVIL DEFENSE SURVEY PLANNED BY MICHIGAN STATE UNIVERSITY

AMA Washington Letter 84–85

Federal Civil Defense Administration has contracted with Michigan State University to conduct a coast-to-coast survey of the effectiveness of civil defense operations in relation to community organization and local governments. Already the survey team has sent out questionnaires to officials in 250 cities officially designated as target areas and to 900 sample counties adjacent to these areas. Commented FCDA: "The final report by the university's survey team will consist of an analysis of the present-day situation in civil defense and specific recommendations for future development of civil defense organizations in cities and counties." A House Government Operations subcommittee headed by Rep. Holifield (D., Calif.) has made an extensive study of all phases of civil defense and is prepared to push for a bill in the next Congress creating a Department of Civil Defense with full cabinet status.

Scientific Papers

A CASE OF NEPHROTIC SYNDROME TREATED WITH ACTH

L. R. SCHOOLMAN, M.D.

Professional Building, Frederick, Maryland

Present management of the nephrotic syndrome has the fundamental defect of not removing the underlying cause. This is true of most serious medical derangements. But we now have something which tends to reverse the abnormal physiology. We can produce symptomatic improvement and thereby gain time for possible spontaneous healing of the renal lesions. The advent of ACTH has placed a potent new tool in the hands of the research worker and the physician. Its effects have brought new concepts which may revolutionize the treatment of the nephrotic syndrome.

The effect of ACTH on the healthy and nephrotic kidney was studied in the early days of ACTH (1949) when it was being doled out only to medical research centers (1).

The immediate effects on the normal kidney were:

1. Increased excretion of phosphates, uric acid, potassium and nitrogenous products.
2. Increased retention of sodium and water.

The findings on the impaired kidney were:

1. Increased proteinuria during the first few days of treatment which diminished either during or immediately after ACTH administration.
2. Marked diuresis either during or after cessation of ACTH.
3. Reduction of serum cholesterol, phospholipids and neutral fats.
4. Reduction of inflammatory reaction.

Four years later more detailed and additional effects on the nephrotic kidney were described (2) (3) (4).

5. Increase in glomerular filtration rate and improvement in renal plasma flow and tubular function.
6. Greatly increased excretion of urinary corticosteroids and 17-Ketosteroids with reduction of abnormal sodium retaining power of urinary corticoids.
7. Restoration of normal capacity of the renal tubule to reject sodium.

Important effects on the blood were noted:

1. Increase in serum albumin concentration and plasma protein.
2. Restoration of normal electrophoretic pattern of the blood except for globulin which remains low.
3. Increase in diminished serum complement concentration.
4. Reduction in sedimentation rate.
5. Reduction of blood concentration of antidiuretic hormone.

Immunological effects were also found in nephrotics with a low serum complement. ACTH caused a rise in the serum complement which preceded the diuresis and reached its peak 14 to 16 days after the beginning of the treatment. A drop in serum complement preceded a relapse. No such rise in serum complement was found in any other disease tested with ACTH (5). Relapse could be prevented by interrupted ACTH or Cortisone therapy (6). It was postulated that the low serum complement found in the edema phase was caused by the binding of

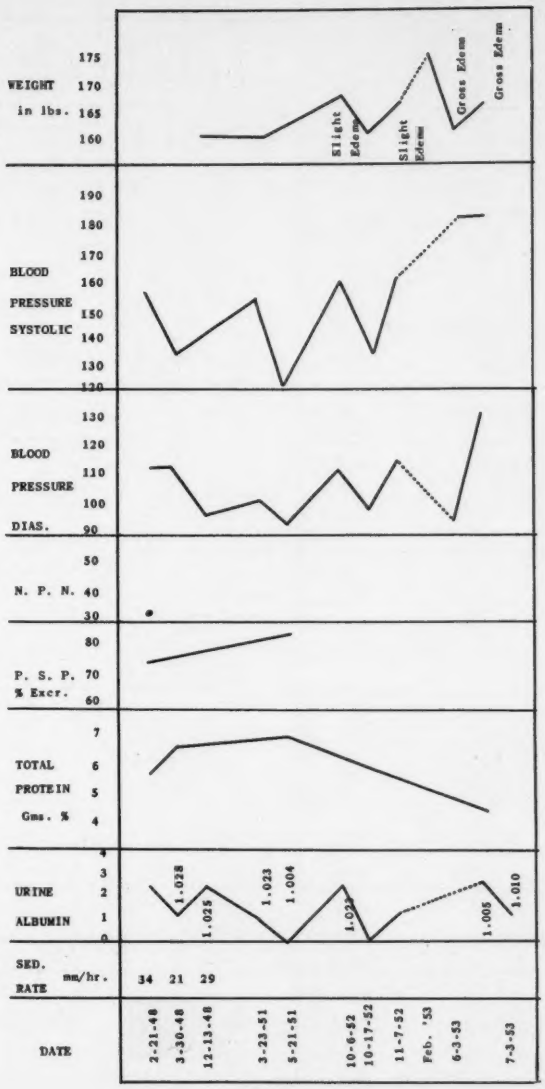

FIG. 1

the complement in an antigen antibody reaction in which the basement membrane of the glomerulus was the antigen. This is a very interesting premise in view of the widely held concept that acute glomerulonephritis is a hypersensitivity reaction.

Further evidence in this direction is furnished by the finding that ACTH produced a great decrease in glomerular permeability to albumin in nephrotic cases with or without edema (7). If ACTH and Cortisone exert their beneficial effect in nephrosis by disrupting a detrimental antigen antibody bondage, this would be another example of the many specific forms of pathogenic hypersensitivity such as bronchial asthma, drug allergy and serum sickness in which these hor-

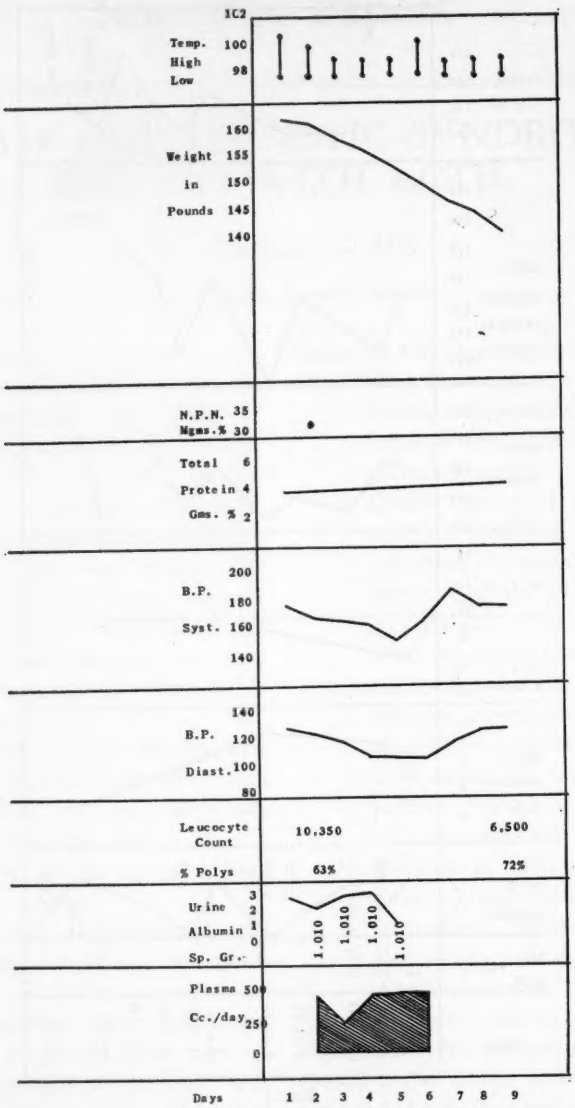

FIG. 2

mones are so specific. It raises the question as to whether they might not be indicated in acute glomerulonephritis.

The dosage of ACTH in the treatment of Nephrosis has not been uniform. One worker administered 150–200 mg. ACTH per square meter per 24 hours, intramuscularly in four equal doses, every six hours for 10 days (8). For the 45 children studied, aged 2 to 12, this amounted to 80–140 mg. per day. In another study older children were given 50 to 75 mg. and adults 150–160 mg. on a similar intramuscular schedule. Several patients were given 25 to 50 mg. per day intravenously instead of intramus-

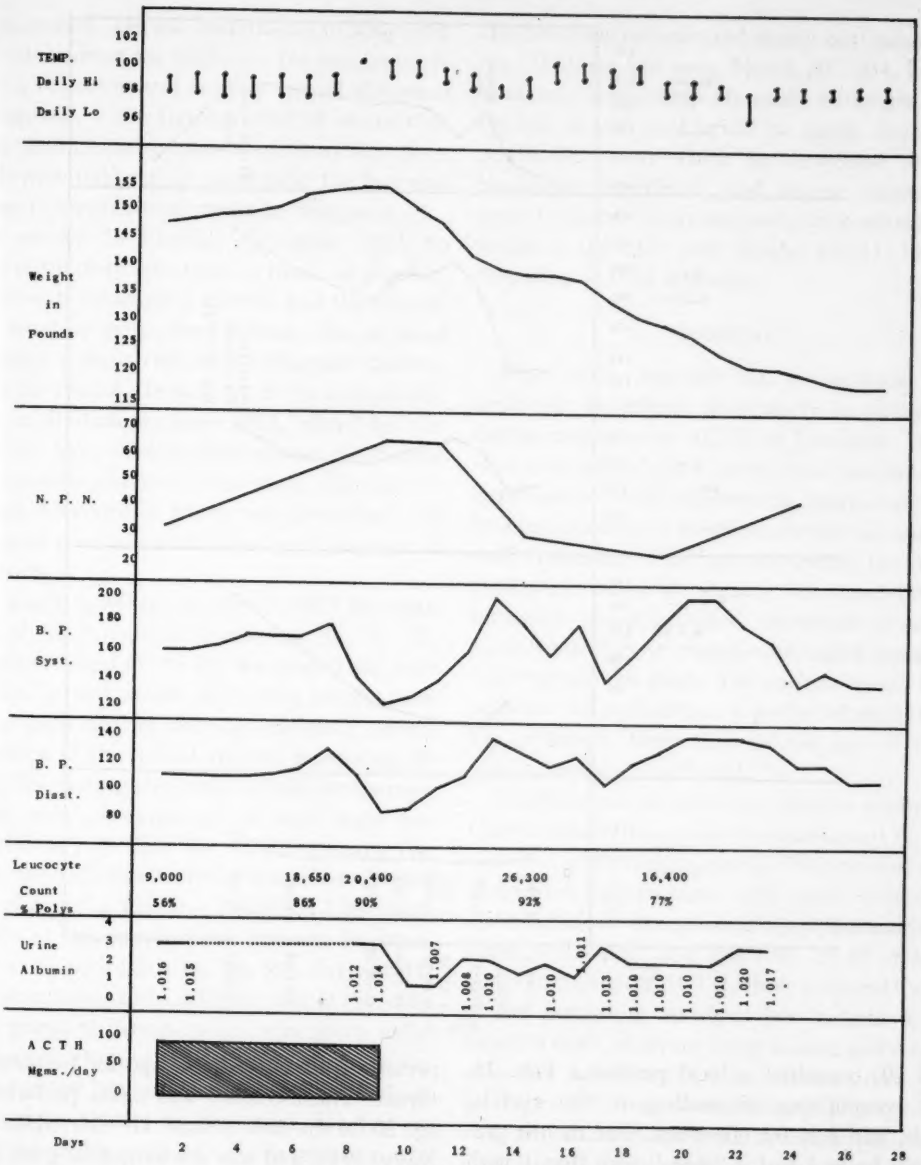

FIG. 3

cularly with similarly good results (2). A third investigator felt that 100 mg. per day was the optimum dose in young children and that a larger dosage had no advantage (3). A fourth used 100 mg. per day in both children and adults (6). A fifth investigator in a larger series of 42 nephrotics used 50 mg. intramuscularly per day divided in 4 equally spaced injections or 20 mg. of ACTH gel twice a day for 10 to 14 days in young children and 75 mg. per day in the adults and older children (9).

Case Report: R. K., white, male, salesman,

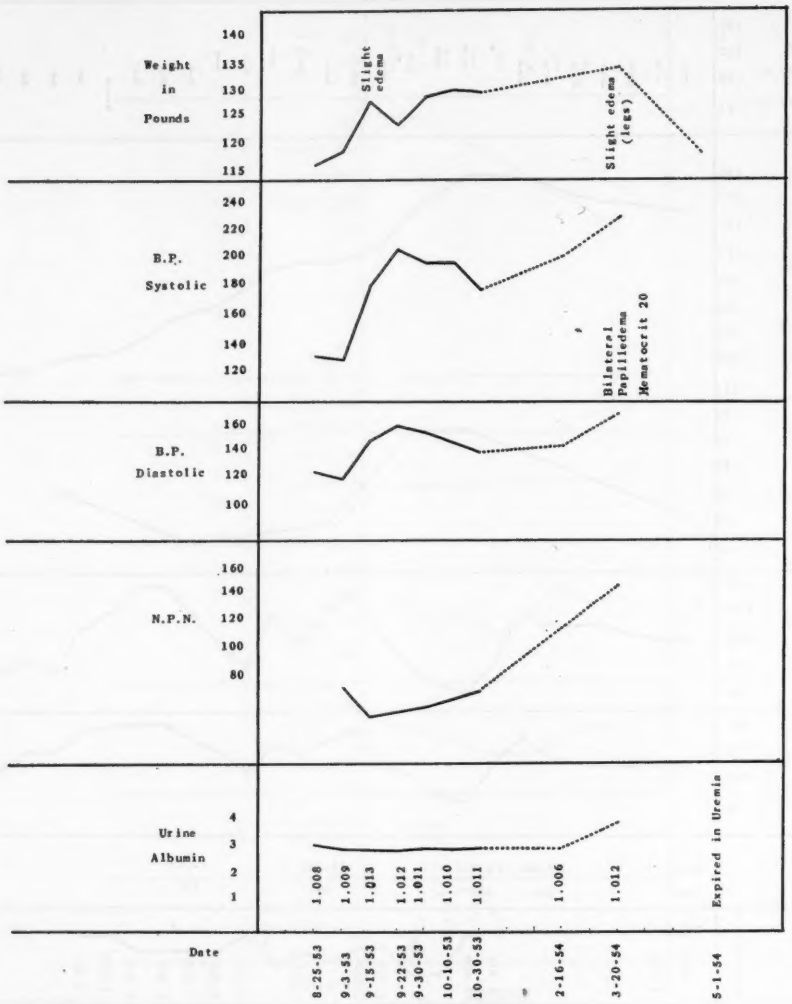

FIG. 4

aged 29, consulted a local physician Feb. 28, 1948 complaining of swelling of the eyelids, hands, and feet for one week. One month previously he had had a "strep" sore throat with fever. His past history disclosed at 6 years of age a "sore throat" diagnosed as Diphtheria, followed by weeks of painful swelling of the knees and ankles. During this illness he had had a period of anuria of 2 days with subsequent spontaneous diuresis after which he recovered promptly. Tonsillectomy and adenoidectomy was performed at 12 years of age for frequent sore throat. Tonsillectomy was again performed at age 20 for the same reason. He entered the U. S. Navy, 1944, and was discharged in good health in 1946.

When seen on Feb. 28, 1948 he was treated for his presenting complaints with bed rest for 6 weeks after which he was able to return to work. He reappeared 12/13/48 complaining of fatigue and swelling of the upper eyelids in the morning. He had no apparent edema and was able to

continue work. He was hospitalized in May 1951 for evaluation of his nephritis. He was found to be in a remission and entirely free of abnormal findings (fig. 1). In October 1952 he stated that he had had frequent upper respiratory infections which were followed by swelling of the face and extremities which took weeks to disappear.

He moved to Florida, November 1952, to avoid respiratory infections as much as possible. He did well for about 2 months and then developed marked generalized edema. He received injections of mercurials with subsequent diminution of the edema. He was referred to a diagnostic clinic in Baltimore, June 1953, where he was found to have considerable edema. A chronic right maxillary sinusitis was found. He did not tolerate Aureomycin which was prescribed and developed diarrhea with subsequent increase of his edema.

He was hospitalized on July 3, 1953 for treatment of his Nephrotic Syndrome (fig. 2). His admission weight of 165 lbs. was only 5 lbs. more than his normal weight of 2 years before; however, a great deal of this was obviously edema. Narrowing of the retinal arteries was noted. He lost 20 lbs. during the course of plasma therapy. Edema soon increased and he was again hospitalized on July 25th for ACTH therapy (fig. 3). During this treatment he was given 300,000 units of aqueous Procaine Penicillin I.M. daily. In spite of this prophylactic measure he developed acute peritonitis on the 9th day. ACTH was discontinued and 1,000,000 units of Penicillin and 2 grams of Streptomycin were given daily. After seven stormy days during which he developed severe headache and a small hemorrhage of the right retina, he recovered. He lost an additional 28 lbs. and was discharged from the hospital weighing 118 lbs. This was apparently his normal weight. His weight 40 days before had been 162.

This remission did not last long. Before he returned to Florida in November 1953 he had regained 14 lbs. and showed some edema of the lower legs. Blood pressure and NPN were rising. His condition deteriorated slowly but inexorably (fig. 4) When last seen, March 20, 1954, he had bilateral papilledema. He could no longer read. On his return to Florida he again developed peritonitis, from which he recovered. Severe headaches, nosebleeds, and muscle cramps became frequent. There was very little edema. His weight in the latter part of April was 117 lbs. He died May 1, 1954 in uremia.

Comment

Most cases, but not all, of nephrosis and nephrotic syndrome, particularly in childhood, can be treated with ACTH or Cortisone. Those with congestive failure, acute renal insufficiency, hypertension with papilledema, marked electrolyte imbalance and infection are not suitable for such treatment. The hazards during the initial prediuresis stage of oliguria, increased edema, increased blood pressure, increased azotemia, sudden electrolytic change and rapid spread of infection are too great. The patient should have achieved an equilibrium, a period of stability in his condition. Only then is the use of these potent hormones indicated.

ACTH is not an innocuous drug in nephrosis. Careful supervision must be maintained to prevent and treat complications. The principal ones are severe hypertension with acute congestive heart failure or encephalopathy, hypotonicity of extracellular fluid and infection. In 45 children given 56 courses of ACTH, there occurred 9 cases of low potassium and 8 of low sodium in the blood, 6 cases of severe hypertension and 6 cases of severe infection (8). Four children died (9% mortality), 2 from overwhelming infection (E. coli, and 2 associated with severe hypertension and electrolytic disorders. It is important to note that, in contrast to the classical experience incriminating the pneumonococcus as the complicating pathogen in nephrosis, E. coli and staphylococci were found. This was probably caused by the use of prophylactic antibiotics which were not effective against these organisms. When infection was suspected the antibiotic regimen was

changed and the ACTH discontinued. In a series of 12 nephrotic children treated with ACTH half were given prophylactic antibiotics. The two cases of infection which developed were among the control group (3).

The usual warning signs of infection such as fever and pain may be masked by the anti-inflammatory and antipyretic action of ACTH so that the pathogenic invasion may be overwhelming when first detected. One cannot depend upon leukocytosis as a warning signal. It may develop consistently during ACTH therapy of nephrosis (9). Daily physical examination and frequent blood electrolyte determination are essential to prevent and successfully treat complications.

It is well known that many cases of nephrosis undergo spontaneous remission. One may question whether he is justified in using so sharp a double edged weapon as ACTH, a drug whose use in so deranged a metabolic state as nephrosis, requires such meticulous management. The results obtained by many workers justify its use. For the first time we have an agent with which we can, almost at will, reverse the pathologic physiology of nephrosis. One worker obtained remission in 93% of his 43 cases of children and adults. After 3 years 43% were still edema free (9). And the new technique of interrupted ACTH and Cortisone therapy bids fair to better these hitherto unrivaled results.

Summary

The course of this case of Glomerular Nephritis had been traced over a period of six years. Early in his last year, at the height of his Nephrotic Syndrome, he was treated consecutively with plasma and ACTH. He lost approximately half of the edema on plasma therapy, but was regaining it when ACTH was given. This therapy was abruptly discontinued on the development of severe peritonitis. While recovering from this complication he had a marked diuresis. The marked edema did not recur but renal failure was progressive.

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ARTICLES OF INTEREST

*THE DECLINE AND FALL OF THE U. S. A.

AMOS R. KOONTZ, M.D.

Almost 200 years ago a distinguished historian—Gibbon—wrote a fascinating and informative six volumes on "The Decline and Fall of the Roman Empire." Anyone reading those volumes is impressed by the tremendous change in attitude of the Roman citizen from the early days of Rome through the decline and eventual fall of that empire. The early Roman was imbued with the spirit of making some contribution to his country's welfare. This gradually changed as political opportunists, seeking personal advantage, offered more and more Romans an opportunity to feed at the public trough. They then ceased to be contributors to the welfare of their country, but sat on their haunches and held out their hands for whatever the Roman officials would drop into them.

Anyone even slightly familiar with the history of our country can see a parallel between the history of Rome and the history of the U. S. A. The only difference is that the deterioration has come much faster in this country, and one wonders how much longer we can go on at the present rate before some historian writes six volumes (or more) on "The Decline and Fall of the U. S. A."

One of the things that is heading us for said decline (already in full process) and fall is the colossal octopus—the Veterans Administration—which has its tentacles in every facet of our national life. The following are some of the facts with regard to this colossal organization with which every citizen should be familiar and which will indeed give him concern if he is interested in the welfare of his country:

In 1955 we spent 4 billion dollars on veterans benefits—the third largest item in the Federal budget after defense and interest on the public debt.

In 30 years, if the same benefits remain on the books, the appropriation for veterans will be 20 billion dollars a year and still rising.

Federal social security and old-age pension programs have reduced the need for old soldiers pensions.

The GI Bill of Rights gave to 13 million men educational, business, and career opportunities, which most would not otherwise have enjoyed.

Widows and incapacitated children who survive disabled veterans receive pensions throughout their lifetimes. War veterans who are permanently and totally disabled by ailments entirely unrelated to wartime services are eligible for pensions averaging $70 a month if their incomes are less than $2,700 a year with dependents, or $1,400 without dependents.

The 80 medical schools of the United States operated on a budget of 93 million dollars during the fiscal year 1954–55.

To operate the Federal government medical, health, and related activities during the same fiscal year, approximately 25 times as much money was required, or $2,141,681, 661. This represents one-sixth of the total U. S. health bills (12 billion dollars) as estimated by the Department of Commerce.

According to data supplied by the Veterans Administration in June 1954, 84.3% of the patients discharged in 1952 had been hospitalized for non-service connected disabilities. It is estimated that 87% of the patients presently in VA hospitals have non-service connected disabilities.

The VA facilities are still expanding. VA officials point out that VA has been authorized a total of only 174 hospitals and about 128,000 beds, at which point the system is supposed to "stabilize." Yet the VA itself estimates that if the present trends and admission policies continue, by 1975 the VA will need 266,000 hospital beds and 78,500 domiciliary beds to support the anticipated patient load.

The young house men with whom I have talked are disgusted with the Veterans Administration program, saying that patients are kept in the hospital entirely too long and that the administrators insist on keeping up a certain quota so they will get proper funds for their hospitals. In one case a manager of a Veterans Hospital ordered one of his medical officers to admit two patients on a certain day, so their quota would not fall below what it was supposed to be.

* "Further Notes on the Decline and Fall of the U.S.A.," by Dr. Amos R. Koontz will be published in Volume 5, No. 12, December 1956, Maryland State Medical Journal).

He told him to admit people who were completely well if necessary.

When a patient is operated upon in a Veterans Hospital and has insurance, he collects the insurance himself and the Veterans Administration gets nothing for taking care of him.

One instance is cited in which a veteran had had a leg amputation for a non-service connected disability in a civilian hospital. He wanted to get the government to pay for his prosthesis, but could not get this done without being admitted to a Veterans hospital. He got admitted on some pretext, and then after being admitted, the policy being to give him anything he needed, he got his artificial leg at the taxpayer's expense.

The Problem of Service Presumption.—Multiple sclerosis, tuberculosis, psychoses, and other diseases, are presumed to be service connected if they make their appearance within a certain length of time after the veteran has left the service. If the present trend continues, undoubtedly subsequent Congresses will add new diseases to the list and increase the length of time after discharge from the service for which service presumption is allowed. The question is whether the matter of service presumption should be one of legislative fiat or of medical opinion. It is proposed that the A.M.A. offer the services of committees of doctors to pass on service presumption, free of charge, and eliminate legislative fiat altogether. The men on these committees could be rotated so as not to make it too burdensome. This, of course, would require a change in the law. The American Legion employs a physician as a lobbyist in Washington, who is very clever at working on the feelings and sensibilities of Congressmen, and in getting them to pass bills such as the multiple sclerosis bill, and increasing the service presumption time.

Only recently were we able to get a bill passed limiting service presumption, so far as teeth were concerned, to six months after discharge from the service. Prior to that if a man had a record of any dental defect while he was in the service, he could get continuous dental care no matter how long after he left the service. Over half the dentists were on the pay roll for this, so they would not fight the bill. When this bill was repealed and the service presumption limited to six months, 600,000 veterans were removed from Federal largess.

Home Town Care Program.—A great deal of veterans' service connected care was being done in local towns by private physicians and some is still being so done. However, the Veterans Administration in a great many localities has arbitrarily cancelled the provisions for it. Recently a ruling was passed that 13 different procedures, one of which was intravenous pyelogram, had to be done in hospitals instead of in doctors' offices. An intravenous pyelogram, which could be done very simply in a doctor's office, now requires admission to a Veterans Hospital and the patient is kept in six days for it. Very frequently his dependents go on relief while he is in the hospital.

In order to get home town care, a veteran must have a service connected disability. We should keep it that way in order to strengthen our position. However, this means that veterans with non-service connected disabilities by some pretext or another get into a hospital to have their ailments taken care of. If a patient with a non-service connected disability has a disabling operation or accident while he is in the hospital, even though it has no connection with his service, he may become a service connected patient for that disability and, if so, is carried so for the rest of his life. He also may get a pension for it. For instance, if his rectum is accidentally punctured during proctoscopy, or something of that sort, he reaps all the benefits. If he has a partial gastrectomy for peptic ulcer, he gets a pension because of disability and becomes a service connected case.

Stay in Hospital.—It has been pointed out that a patient might go into the Cincinnati General Hospital, for instance, for a certain condition for a period of ten days and the average cost would be $160. If a veteran went into a Veterans Administration Hospital in Cincinnati for the same condition, his stay would be 38 days at an average cost of $750. The same doctors who treated the patient in the Cincinnati General Hospital, would also treat him in the Veterans Administration Hospital, as consultants, adding still more to the taxpayers burden.

Patients with non-service connected disabilities cannot get out-patient service. Therefore, they stay in Veterans Administration hospitals much longer than necessary so that they will not have to have any treatment after they leave the hospital.

Tropical Diseases.—In 1948 fifteen tropical diseases were declared by Congress to be service connected, if shown to exist within one year after separation from active service, or at a time when

standard and accepted treatises indicate that the incubation period thereof commenced during active service. It is not hard to imagine what abuse is possible under such a law.

Non-service Connected Cases Who Cannot Afford Private Hospitalization.—Recently a man with a non-service connected disability, who was driving a Cadillac car, claimed that he could not afford to have his operation in a private hospital. His word had to be taken (as provided by law) and he was admitted to a Veterans Administration hospital. But suppose he had been telling the truth and could not afford to be a private patient? Why should he be taken care of at the expense of the Federal Government? The proper place for him is in his own city or county public hospital or in the public ward of one of the private hospitals. With a non-service connected disability, he has no more claim on the Federal Government than any other citizen.

Also recently a man was taken into a private hospital drunk. It was found that he had $3,900 in his pocket. However, because he was a veteran, he was removed to a Veterans Administration hospital, although it was obvious that his condition (drunkenness) was not service connected.

Residency Training Program.—In order to keep the residency training program going, Veterans Administration hospitals are kept stocked with patients with non-service connected disabilities. The most recent estimate is that 87% of the patients now in Veterans Administration hospitals have non-service connected disabilities. The great number of residents necessary to take care of these patients is the main reason for the paucity of house men in our civilian hospitals. The VA hospitals pay salaries with which civilian hospitals cannot compete. If the VA hospitals were required to take only service connected cases, the VA residency training program would dwindle and that in the civilian hospitals would thereby be improved.

Meeting with American Legion Officials.—Last year officials of the A.M.A. had several meetings with officials of the American Legion. These meetings were held in the hope that both organizations could agree on a policy for veterans' medical care. The meetings were the most encouraging ever held with any veterans organization. The two organizations were in essential agreement on all subjects except the matter of making a special class out of veterans. The American Legion feels that any man who has worn the uniform should be set apart as a special privileged class of citizen. The A.M.A., as well as several past national administrations, have felt that to serve in the armed forces is the duty of a citizen and that he should have no special reward for it, except that if he is disabled while in the service he should have care for his disability at government expense.

What To Do About It!—I venture to make the following suggestions:

1. Doctors are very busy people. Yet it cannot be denied that even with doctors, as with all other Americans, their first duty is their duty as citizens. As citizens it is their duty to keep informed as to what is going on in our country, to use all of their influence to forward measures which will benefit us, and to defeat those which will be harmful.

2. Doctors who are veterans should join the American Legion and work from within the Legion, as well as from without it, to prevent veterans' abuses of medical care.

3. Every doctor should write to his congressman and to both senators protesting against the passage of any bills which will augment the empire building of the Veterans Administration, and advocating the passage of bills which will curtail the domain of this already too far expanded empire.

4. Our State Medical Society should be very active in combatting the evils set forth above and should work in close cooperation with the A.M.A. Federal Medical Services Committee. This committee expects to conduct a vigorous campaign this year against the abuses of veterans' medical care.

What Not To Do About It!—If you happen to be a socialist (and I am sorry to say that there are a few such unrealistic individuals in our profession), you are happy with what is going on. If you are not a socialist, and, if on the contrary, you believe in the private enterprise system, in the dignity and independence of the individual man as developed by the private enterprise system, then by all means do not just sit still and do nothing. If you pursue such a course, you will be contributing to the further Decline and eventual Fall of this once glorious country of ours.

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LEGAL RESPONSIBILITIES OF NURSING HOME OPERATORS[1]

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The nursing home is a comparatively new creature in the law. As a result, the courts are undecided as to how they should be treated. In the cases in which this question has been presented to the courts, nursing homes are treated very similarly to privately owned profit hospitals. Therefore, this discussion will include the liabilities of private hospitals as well as nursing homes.

Privately owned nursing homes and hospitals operated for profit are, as a rule, subject to the same liabilities as other private businesses. There are, of course, certain relationships which confront a nursing home which do not exist in ordinary private business and which may make more hazardous the nursing home operation.

One of these special relationships and one that causes, I believe, the most trouble, is the relationship between the operator and the patient. In any theory of liability, if an operator is to be found liable there must be a showing of a duty owed to the patient by the nursing home operator, and a failure on the part of the operator in carrying out such duty.

What are these duties?

First, the nursing home operator is required to use due care in his dealings with his patients. Nursing home operators must be certain that all necessary provisions are made for the safety and care of the patient, considering the condition of the patient.

Courts throughout the country have held hospitals and nursing homes liable for a variety of injuries. For example, in some cases the failure of a nurse to give constant attention may amount to negligence —even though there is no contract with the nursing home that a nurse must be ever present. The fact that no contract is made for a special nurse to care for a patient who is in extreme danger will not excuse those in charge from providing such attention if the patient's condition warrants such care.

The hospital or nursing home is not an insurer against personal injuries, but it is liable for negligence or wrongful acts.

As a practical matter, legal responsibility is limited to those causes which are closely connected with the result. Such causes may either result from acts or from failure to act. For example, a nursing home operator may in some instances be held liable for installing, insecurely, bedside boards, knowing the likelihood of a particular patient to roll and push against the side of the bed. This would be liability for an act. On the other hand, a nursing home operator may be held liable for failing to install such side boards if the operator knows or has reason to know that the patient *may* roll from side to side.

Some other examples of cases in which hospitals and nursing homes have been held liable include,— injuries resulting from leaky windows or roofs which result in a patient's slipping on a wet surface or contracting another or an additional disease—injury resulting from poison being left in an area or at a location which is accessible to patients and which patients may find and use; injury from contact with open fires; contagious disease, that is, permitting other patients to come in contact with a patient or objects which may result in the spread of such disease —injuries incurred by a patient who escapes; for the negligence of a nurse in applying a hot water bottle; for mistaking and administering one drug for another; for burns inflicted by the use of an X-Ray machine; for improper diagnosis, and also for failure to guard and restrain insane patients. In these cases the hospitals and nursing homes may not only be held liable for injuries to the insane person but also may be held liable for injuries inflicted by such insane persons on other patients or other persons in the nursing home. I will discuss this more fully a bit later.

Again, it should be noted that a nursing home or hospital is not held liable for every injury which may occur. For example, the fact that a patient suffers burns from an electric heating pad does not of itself entitle him to damages. The patient may have used the pad before, and should also have been watchful. His failure to do so may be *contributing* negligence.

Now, what about employees? What liability does the nursing home operator have for the acts of its employees? Here we have another theory of law, that of master and servant.

[1] Presented at Second Annual Nursing Home Administration Institute, College of Special and Continuation Studies, University of Maryland, Baltimore, December 1, 1955.

[2] Assistant Montgomery County Attorney.

The general rule is that a master is subject to liabilities for injuries caused by the conduct of his servants within the scope of their employment. The creation of this relationship depends on the amount of control exercised by the operator over the individual working in his institution. In many instances, this may be a very difficult question. Some are easy. A maid who carries out the instructions of the operator and who, in carrying out such instructions, negligently injures a patient, is without question subjecting the operator to liability.

The relationship of a nurse is more difficult. A nurse generally is under the control of the operator of the hospital or nursing home and acts which she carries out within her scope of employment in doing her regular and routine duty will be transferred to the owner. Of course, if the nurse is carrying out service under the direction of the doctor, the nurse may be acting as an independent contractor like the doctor and the operator may not be liable. Each such case must be decided on its own facts.

This does point up one very important matter. The necessity for nursing home operators to obtain the best possible employees, the most trained and skilled, to carry on the work of the nursing home. The necessity for such care in selecting proper and qualified employees must not be overemphasized, because of the tremendous part it may play in reducing the operator's liability.

Now then, what is the relationship of the physician to the nursing home? Generally speaking, as has been noted, the nurses, orderlies and maids employed by a hospital or nursing home are considered its servants, but physicians treating patients at the institution are generally considered independent contractors. This is, however, sometimes subject to such limitations as cases in which the patient in a hospital or nursing home includes in his contract or agreement with such hospital or nursing home, the provision for medical care. In such event, physicians have often been held to be the employee of the hospital or nursing home and the nursing home has been held liable along with the physicians.

It may be stated, however, as a general rule that a physician is an independent contractor and that the hospital or nursing home is generally not liable for such physician's acts.

However, it may be well to re-examine rather carefully the legal relationship between your hospital or nursing home and your physicians with the view to ascertaining that this relationship of independent contractor does actually exist. Of course, if the physician is the owner of the nursing home and includes such medical services in the hospital and nursing home service, then the nursing home, along with the physician, may well be held liable for any injury suffered by any of the patients.

That, in a very general way, sets out the relationship of patient, employee, and physician with the nursing home.

There is, however, another very substantial source of trouble for nursing homes and hospitals. This concern injuries suffered by visitors and strangers. There have been numerous instances in which courts have found hospitals and nursing homes liable for injuries suffered by persons on nursing home or hospital property.

There are three types of visitors: the licensee, the business visitor and the trespasser.

The licensee is generally defined as a person who is privileged to enter upon the property by virtue of the owner's consent. The owner is under no obligation to exercise care to make the premises safe for his reception and is under no duty to him, except to use reasonable care to discover him and avoid injury to him in carrying on activities on the property. A licensee has been said to be a person who is neither a customer, a servant nor a trespasser and does not stand in any contractual relation with the owner of the premises. He is permitted to go on the premises for his own interest, convenience or gratification and his presence is not invited but merely tolerated. Salesmen, in most cases, are considered licensees.

However, a much greater duty is imposed on hospitals and nursing homes with respect to guests and visitors of patients. Such persons are considered business visitors. Generally speaking, a business visitor is considered to be a person who is invited or permitted to enter and remain upon the property for a purpose connected with the business carried on. In this relationship, the nursing home operator is required to protect the visitors with reasonable diligence.

Many cases concerning injuries to hospital and nursing home visitors appear in the courts throughout the land. Such cases include—injuries resulting

from tripping over mops, buckets and other apparatus which are left on the floor where persons are apt to walk—visitors being caught in elevator doors or in revolving doors—visitors falling as a result of snow or ice at the entrances of hospitals and nursing homes —and another, and a great source of trouble to hospitals and nursing homes, visitors injuring themselves on slippery and waxed floors.

In each of these cases, the question of liability depends on the particular set of circumstances. Furthermore, in order for a visitor to recover damages for injury the visitor must show that he himself was not negligent and that his own fault did not contribute to the accident.

Now, to get back to the care of infirm or insane patients. As a general rule a private hospital or nursing home, in which patients are placed for treatment by their physicians, is under the duty to exercise such reasonable care in looking after and protecting the patient as the patient's condition may require. This duty includes safeguarding and protecting the patient from any number of reasonably to be anticipated dangers. The hospital is placed under the necessity of watching the patient in proportion to the illness of the patient which make him incapable of looking after his own safety.

It is the duty of a hospital or nursing home to provide competent attendants to see that the patient does not hurt himself while semi-conscious. It is the duty of a nursing home and hospital to provide proper care to see that a person in a delirium is properly attended. As a practical matter the hospital or nursing home must protect the patient from the consequences of his own irrational act. And it is incumbent upon such operators and their employees to use the degree of care necessary to afford such protection. During the absence of the physicians the nurse necessarily has charge of the patient and the responsibility of the nursing home for the safety of the patient continues. The courts have held in many cases that a patient who was delirious and inflicted injury on himself has a good cause of action against the hospital or nursing home because the hospital or nursing home should have foreseen such an occurrence and provided such necessary protection.

Of course, with respect to these problems that I have presented, hospitals and nursing homes may in many instances, protect themselves by obtaining proper and sufficient insurance. Great care, however, should be taken that the insurance is sufficient in amount and coverage to protect your operation. A review of your problems with an attorney would be most desirable.

So much for liability for negligence. Again, let me reiterate that what I have said here is very general and that each particular situation must be considered on the particular facts of that situation.

We come now to a brief discussion of contracts—particularly, service contracts entered into between the nursing home operator and the patients.

One big question faced by the nursing home operator concerns lifetime contracts. These contracts, are for the duration of the patient's life and generally provide that the patient's needs will be serviced during the course of the patient's life. Sometimes the fee provides for all of the patient's property and assets. Sometimes it merely states an agreed amount.

Initially, it should be noted, that this kind of contract is dangerous. It is dangerous for the operator because the operator does not know how long the patient may survive and how much service the patient may require. In other words, it may easily turn out to be a very bad deal for the operator.

On the other hand, it is dangerous for the patient, because there is always the danger that an unscrupulous operator, once having obtained the assets of the patient, will not provide the necessary service.

Furthermore, courts view with a very jaundiced eye these kinds of agreements. There is always the danger that these contracts may be challenged by either the patient or his family. A usual basis for challenging such a contract, is that undue influence has been exerted on the patient by the operator to enter into such an arrangement. Whether undue influence does exist in any particular case will depend on a consideration of the special facts involved. These include such things as the character of the transaction, the mental condition of the individual entering into the contract and the relationship of the parties to each other.

In cases where the mind of one of the parties is enfeebled by old age, sickness, great stress or other like causes, and is therefore rendered incapable of resisting undue pressure, a contract made under such circumstances will generally be regarded as being made under undue influence.

The nursing home operators who enter into these

kind of contracts are possibly inviting lawsuits. This is particularly true if the patient has a family or any relatives and all of the patient's assets are given to the institution for purposes of his or her care. There is always the very real possibility of a suit to the effect that unusual or undue influence had been used by the operator to obtain these assets.

It cannot be sufficiently emphasized that such contracts present real dangers and it is, at least my own belief, that they should not be encouraged. However, if an operator decides to enter into such a contract, it is most important that the contract be in writing and carefully reviewed by legal counsel.

Now with respect to the general requirements of a contract. Again, great care should be taken in the preparation of any contract. If possible, all services to be rendered should be set forth and the exact amount of fee to be charged should also be clearly stated. Contracts should, to protect both the operator and the patient, be reduced to writing. It may be well for your respective associations to consider preparing a form of contract which could handle most of these situations. In that way, the operator as well as the patient, would obtain the best possible results.

Let me say in closing, that what I have stated here today, is of necessity in the broadest of generalities.

Each situation must be considered separately on the basis of its particular facts and circumstances. Furthermore, in many cases trouble may be avoided if legal counsel is sought before the injury or claim.

Lawsuits are expensive, and as a practical matter, it is much cheaper, both from the standpoint of fees and good public relations, to try to prevent these problems before they occur.

Silver Spring Building
Georgia Avenue & Cameron Street
Silver Spring, Maryland

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

Miners Hospital, Frostburg, Md. Established as State Owned Hospital

Dr. W. Oliver McLane was elected president of the Miner's Hospital Staff, at a regular monthly staff meeting held in July. Dr. McLane lately resigned as a member of the Board of Directors of the Miners Hospital, after serving twenty-three years on the Board, as the president and as the secretary. Relinquishing his position as a member of the Board of Directors, he felt that he would have more time to devote to his private medical practice.

Miners Hospital

Dr. McLane is a true general practitioner in every sense of the word. He visits the sick, treats the sick and operates upon the sick. His consulting practice is extensive and he has served the Allegany-Garrett County Medical Society, as president. He is the son of a former physician of Frostburg. He graduated at the University of Maryland in 1924, after attending Gettysburg College, at Gettysburg, Pennsylvania. He is now serving on the Council of the Medical and Chirurgical Faculty, having served since 1947. He is married and the father of six children. He is active in state politics and takes an active part in all civic affairs in Frostburg.

The Office of Deputy Medical Examiner

In 1939, Dr. Herbert V. Deming, of Cumberland, Maryland, was appointed Coroner, by the Honorable Herbert R. O'Conor, Governor.

In 1946, he was appointed Deputy Medical Examiner, by the Maryland Post Mortem Examiner Commission, pursuant to the powers conferred on the Commission by Chapter 70, of the State Laws of Maryland, of 1941.

The first Deputy Medical Examiner was Dr. Linne R. Corson, who served from 1941 to 1946.

Previous to becoming Deputy Medical Examiner, Dr. Deming pursued the practice of medicine in Allegany County, in 1908. He graduated from the Atlantic Medical College, Baltimore, Maryland in 1907 and served an interneship at St. Lukes Hospital, for one year thereafter.

Dr. Deming is a member of the Staffs of Sacred Heart Hospital and the Memorial Hospital, in Cumberland, Md. For many years, he was secretary of the Allegany County Medical Society, before it merged with Garrett County and forming the Allegany-Garrett County Medical Society.

It is the duty of the Deputy Medical Examiner, after he is informed by the States Attorney, of the death of any citizen in Allegany County, as a result of violence, or by suicide, or by casualty, or suddenly when in apparent health, or when unattended by a physician, or in a suspicious or unusual manner, to immediately go to the dead body and take charge of the same. He fully investigates the essential facts concerning the medical causes of death and may take the names and addresses of as many witnesses thereto as may be practicable to obtain, and, before leaving the premises shall reduce such facts, as he may deem necessary to writing and file the same in his office. In the absence of a Police Officer, the Medical Examiner shall in the absence of the next of kin of the deceased person, take possession of all property of value found on such person, make an exact inventory and deliver such property to the police department, or Sheriff of Allegany County and takes possession of any object or articles, which, in his opinion, may be useful in establishing the cause of death, and deliver them to the States' Attorney.

If the cause of such death shall be established beyond a reasonable doubt, the Medical Examiner will report and file in his office within thirty days after his notification of such death. If, however, in the opinion of the Medical Examiner, an autopsy is necessary, it shall be performed by the Chief Medical Examiner, an Assistant Medical Examiner, or by such competent pathologists as may be authorized by the Chief Medical Examiner. He has the power to administer oaths and affirmations, and take affidavits and make examinations as to any matter within the jurisdiction of his office.

Within the definition of the Deputy Medical Examiner, a "Medical Examiner's case" means any death, which is the result, wholly or in a part, of a casualty, or accident, homicide, poisoning, suicide, criminal abortion, rape, therapeutic misadventure, drowning, or a death of a suspicious or unusual nature, or of an apparently healthy person. A stillbirth or neonatal death, or accident room or hospital death in which the cause of death has been established by the hospital physician and is due to disease, and free from evidence of criminal or accidental nature, shall not be considered as a Medical Examiner case. A case which is dead on arrival at the hospital, however, shall be considered a Medical Examiner case unless the physician who pronounces death has been in previous attendance on the patient.

Certain Medical Examiner cases may be released to a hospital for autopsy, under certain circumstances. For example, if the hospital obtains permission for an autopsy by the hospital pathologist, from the nearest of kin or other proper relative of the deceased, or if neither is living or available, from a friend, church, welfare or fraternal association that will assume responsibility for burial expenses, or from the State Anatomical Board; and provided the death certificate in each such case is countersigned by the Medical Examiner. The following cases may be autopsied:

1. Death from acute or chronic alcoholism without manifestation of trauma.
2. Death from accidental burns, occurring in the home.
3. Death, or sudden death, associated with a therapeutic procedure.
4. Anesthetic death.
5. Death following a fracture in an elderly person and resulting from a simple fall in the home.

In the case of an anesthetic death occurring in a hospital in Allegany County, the hospital shall notify immediately by telephone, the Deputy Medical Examiner of Allegany County.

FREDERICK COUNTY MEDICAL SOCIETY

LOUIS R. SCHOOLMAN, M.D.

Journal Representative

The regular meeting was held June 19 at the Schley Inn at Braddock Heights. Mrs. Fischer's justly famous apple strudel was as good as ever. The speaker of the evening was Dr. Alexander Schaffer, associate professor of pediatrics at The Johns Hopkins Hospital. He gave a very interesting illustrated talk on dyspnea in the newborn.

The Society is taking its annual summer rest and will not meet until September.

Dr. William Meredith Smith, the dean of the Frederick County surgeons, was admitted to the Frederick Memorial Hospital as an acute medical emergency June 19. After a few days, although still bedridden, he was again his debonair self.

During July the county lost two of its elder practitioners. Dr. C. A. Stultz died July 1 aged 89. He had practiced in Woodsboro 56 years. Dr. Ulysses G. Bourne died July 15 aged 83. He had practiced in Frederick 51 years.

Hospital News

The medical staff of the hospital met June 4. Dr. B. O. Thomas, Jr. presented a case of a Caesarian section who had a lower nephron nephrosis caused by a transfusion reaction. Dr. Lea presented a case of cholecystectomy with extensive endometriosis of the sigmoid simulating carcinoma.

The case at the C.P.C. was a brain abscess which had metastasized from a bronchiectasis.

The hospital staff met July 2. Drs. J. S. Fifer and T. E. Stone presented a case of proteus bacteriemia whose focus was in the middle ear. A case of subdural hematoma in a patient of Dr. R. R. Martin's was also presented.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

HANS WODAK, M.D.

Journal Representative

As an experiment our June meeting was held at the Prince George's Golf and Country Club and was in the form of a dinner meeting. The Society picked up the check for some 50 members at the rate of $3.50 per person: Everyone who attended thought so well of the plan that a special committee was appointed to ascertain whether the membership favored an increase in dues so that all or at least every other meeting could be a dinner meeting. All our regular meetings are held in the evening and the idea is that with a dinner meeting we can begin earlier and hence quit sooner.

Dr. Wolcott Etienne's report on the Medical and Chirurgical Faculty's financial affairs ended with his motion that we approve the recent proposal that assessment be increased $15.00 for the Counties and $20.00 for Baltimore City. The motion carried unanimously.

Following our business meeting the Society heard from our scientific speaker of the evening, Dr. R Adams Cowley, Director of Thoracic Surgery, University of Maryland. Dr. Cowley presented the topic, "Coronary Artery Disease."

CABINET STATUS TO BE ASKED FOR U.S. CIVIL DEFENSE AGENCY

AMA Washington Letter 84–84

The next Congress will be asked to pass legislation creating a cabinet-rank Department of Civil Defense, and to make drastic changes in the entire national civil defense concept. Recommendations appeared in a report by the Holifield House subcommittee, following a year's study. The report was published just at the end of the 84th Congress, and no attempt was made to get action. The proposed department would merge civil defense work of the Federal Civil Defense Administration and the Office of Defense Mobilization. Other points in the report:

1. Neither the ODM nor FCDA has fully grasped the technical, economic or administrative requirements of civil defense. Their reliance on evacuation is "weak, ineffective and dangerously shortsighted." The committee instead called for a national program of shelter building, financed largely by the federal government.

2. Industrial dispersal has "little promise" because of powerful budgetary obstacles and "sporadic and limited efforts of the federal government in promoting dispersal."

3. Unless a strong national civilian program is developed, the military will expand its civil defense role at the expense of civilian authorities. The subcommittee urges the Secretary of Defense, in consultation with FCDA, to set up an effective program to train active and reserve personnel in civil defense duties.

4. "Enormous duplication of paperwork" is resulting from the so-called "survival plan" studies now being conducted in 25 cities and they should be abandoned. Furthermore, FCDA is investing $20 million in the two-year projects, the subcommittee says, as a means of evading the legislative ban on federal contributions to pay administrative expense of state and local civil defense organizations.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

LIBRARY CHATTER

LOUISE D. C. KING

Librarian

Although our Staff is not yet complete, we are happy to have Miss Florence Woods back with us, and we hope that by the time this goes to press we will have succeeded in obtaining a Library Assistant who will be capable of taking over the cataloguing.

The County Members have availed themselves of library service more frequently than in the past but we feel the vast storehouse of information in the Library is not used to its full capacity by many of our Members. We shall welcome any suggestions as to future usefulness and suggest that one way might be to have a few texts and journals sent for various local meetings which might be consulted by those attending. If you would write us, giving the subject matter to be discussed and the date and number (approximately) attending, we will be glad to mail you literature along the lines indicated. The person making the request would, of course, be responsible for the return of the books.

As this is our first Library Chatter, may we take this opportunity to greet old friends and new ones alike, and to express the hope we can be of service to many of you in the months to come.

1211 Cathedral Street
Baltimore 1, Maryland

PRESIDENT EMPHASIZES NEED FOR CONSTRUCTION AID TO MEDICAL SCHOOLS

AMA Washington Letter 84–84

In signing the bill providing a three-year federal grants program to help in constructing and equipping medical research facilities, President Eisenhower criticized Congress for not voting the same type of assistance to schools training physicians, dentists and other professional medical personnel. He said he was hopeful the next Congress would take action along these lines. The President declared in part:

"The se professional schools are now providing practically all of the skilled scientific and profess'o nal talent . . . to maintain and improve the health of the nation. By assisting them . . . to r ehabilitate or increase the sorely needed facilities, the government can provide the needed assistance without interference with their educational policies and independence. Although the funds for research facilities will be extremely helpful, we should extend the assistance to include the laboratories where future health research personnel are being developed. In medical and dental schools, space for research and teaching functions are so closely interrelated with one another that no clear line can be drawn between them."

The President described the $90 million, three-year program for research grants as "inadequate." He noted that the administration had asked for a $250 million, five-year program of aid to medical and other schools in the health fields.

Woman's Auxiliary Medical and Chirurgical Faculty

MRS. GERALD W. LEVAN, *Auxiliary Editor*

MESSAGE FROM THE PRESIDENT

MRS. HOMER ULRIC TODD, SR.

The new picture on this page means that another year has passed and another convention has been held and a new group of members have agreed to serve in the capacity of officers and committee chairmen for the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland.

Each officer and chairman has been carefully chosen because she has shown capability and enthusiasm for the task to be performed.

It will be their pleasure, by example and inspiration, to interpret their duties of office in conformity with the regulations, standards, policies and basic principles of the National Auxiliary, to each of the five auxiliaries which make up the membership of the State Auxiliary.

MRS. HOMER U. TODD, SR.

President, Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland, 1956–57

Through active participation on the local levels, our members will strive to help the lay public understand the function, policies and aims of the medical profession. To select and promote educational and service activities relating to health and medical care needs is just one phase of our work. To make each Auxiliary member aware of her responsibility as an ambassador of good will for the medical profession in her daily contacts is another.

Giving of scholarships for nurses and actively recruiting personnel for careers in the many other health services has been and will continue to be a major project for the auxiliaries. Raising of money for the American Medical Education Foundation has been given impetus the last three years. Learning what to do in the event of disaster has been the work of the Civil Defense Committee. Mental Health is still another field we have been approaching cautiously, striving to educate ourselves and the public to the appalling needs in this field. Keeping abreast of legislation pertaining to the medical profession is still another and, on and on, are the many phases of auxiliary activities. But probably best of all are the very wonderful times we enjoy by social contact and good fellowship of working together on mutual projects.

A great many doctors have only a vague idea of what an Auxiliary is supposed to be. So this year we are going to tell you, by this printed page so graciously allotted to us in this, your publication, and by a campaign by our members.

We ask only that you, our most dearly beloved doctors, strive to know us, support us by your encouragement and help us to become a forceful organization.

WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY

Officers—1956–1957

President, Mrs. Homer U. Todd, Sr., Baltimore; *President-Elect,* Mrs. David S. Clayman, Riverdale; *1st Vice President,* Mrs. Conrad Acton, Baltimore; *2nd Vice President,* Mrs. D. Delmas Caples, Reisterstown; *3rd Vice President,* Mrs. Robert

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WOMAN'S AUXILIARY TO THE *BALTIMORE CITY* MEDICAL SOCIETY

Officers—1956–1957

President, Mrs. E. Ellsworth Cook, Jr.; *President-Elect*, Mrs. Whitmer B. Firor; *1st. Vice President*, Mrs. Newland E. Day; *2nd. Vice President*, Mrs. William S. Stone; *Recording Secretary*, Mrs. Raymond L. Markley; *Corresponding Secretary*, Mrs. Robert W. Garis; *Treasurer*, Mrs. W. Kenneth Mansfield; *Parliamentarian*, Mrs. Moses Paulson

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WOMAN'S AUXILIARY TO THE *BALTIMORE COUNTY* MEDICAL ASSOCIATION

Officers—1956–1957

President, Mrs. Hans W. Constadt; *Vice President*, Mrs. D. Delmas Caples; *Treasurer*, Mrs. Elliott C. Flick; *Secretary*, Mrs. Raymond Cunningham

COMMITTEE CHAIRMEN

Public Relations, Mrs. Charles H. Williams; *Legislation*, Mrs. Richard VonRigler; *Bulletin*, Mrs. Charles Kerr; *Nurse Recruitment*, Mrs. Louis Dalmau; *Dortors' Day*, Mrs. Lee Fargo; *Press & Publicity*, Mrs. T. Edgie Russell; *Mental Health*, Mrs. Harold Weinberg; *A.M.E.F. Fund*, Mrs. Harry B. Smith; *Program*, Mrs. D. Delmas Caples; *Civil Defense*, Mrs. L. T. Chance; *"Today's Health"*, Mrs. Thomas Wheeler; *Revisions*, Mrs. Martin Strobel; *Hospitality*, Mrs. John C. Baier; *Membership*, Mrs. Richard Seidenberg

WOMAN'S AUXILIARY TO THE *MONTGOMERY COUNTY* MEDICAL SOCIETY

Officers—1956–1957

President, Mrs. DeWitt E. DeLawter; *1st. Vice President*, Mrs. Michael Buckley; *2nd. Vice President*, Mrs. John Robben; *Recording Secretary*, Mrs. John Haberlin; *Corresponding Secretary*, Mrs. Theodore Flaiz; *Treasurer*, Mrs. Norman Shoemaker

COMMITTEE CHAIRMEN

Program, Mrs. Thomas Edison; *Ways and Means*, Mrs. John Robben; *Publicity*, Mrs. J. Marion Bankhead; *Nurse Recruitment*, Mrs. Jack Schumacher; *Hospitality*, Mrs. William Aud; *Mental Health*, Mrs. Henry Laughlin; *Membership*, Mrs. Emmett Madigan; *Legislation*, Mrs. Richard Lukes; *Today's Health-Bulletin*, Mrs. Andrew Brennan

WOMAN'S AUXILIARY TO THE *PRINCE GEORGE'S COUNTY* MEDICAL SOCIETY

Officers—1956–1957

President, Mrs. John S. Haught; *Vice-President*, Mrs. Albert Roth; *Corr. Secretary*, Mrs. Leon Gallin; *Recording Sec.*, Mrs. Oscar Lavine; *Treasurer*, Mrs. John Perkins

COMMITTEE CHAIRMEN

Program, Mrs. Norman Comeau, Mrs. William A. Holbrook, Jr.; *Hospitality*, Mrs. Ronald Fleischer; *Today's Health & Bulletin*, Mrs. Benjamin Miller; *Mental Health*, Mrs. Thomas M. Hutchins; *Publicity*, Mrs. W. B. Moyers; *Civil Defense*, Mrs. Henry Wolfe; *Doctor's Day*, Mrs. W. B. Hagan; *Membership*, Mrs. F. E. Musser

WOMAN'S AUXILIARY TO THE *WASHINGTON COUNTY* MEDICAL SOCIETY

Officers—1956–1957

President, Mrs. B. B. Kneisley; *President-Elect & 1st. Vice Pres.*, Mrs. J. G. Warden; *2nd. Vice-President*, Mrs. Ross Cameron; *Recording Secretary*, Mrs. George Jennings; *Corresponding Secretary*, Mrs. Robert Conrad; *Treasurer*, Mrs. Archie Cohen; *Parliamentarian*, Mrs. Henry Graff

COMMITTEE CHAIRMEN

A.M.E.F.-Publicity-Public Relations, Mrs. Jack Beachley; *Finance-Ways & Means*, Mrs. Howard N. Weeks; *Magazines*, Mrs. F. H. Fairchild; *Publications*, Mrs. J. H. Ramsey; *Historian*, Mrs. Ernest F. Poole; *Mental Health*, Mrs. Ross Cameron; *Future Nurses Clubs*, Mrs. Frank Lusby; *Legislation*, Mrs. O. H. Binkley; *Membership*, Mrs. J. J. Dobbie; *Nurse Recruitment*, Mrs. Philip Hirshman; *Hospitality*, Mrs. Robert Campbell; *Program*, Mrs. J. G. Warden; *Doctors' Day*, Mrs. Samuel Wells; *Medical Library*, Mrs. J. G. Warden, Mrs. Ernest F. Poole

Health Departments

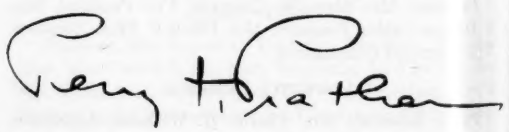
STATE DEPARTMENT OF HEALTH

Training of Medical Students in Public Health

Since 1951, the State Department of Health in Maryland has cooperated with medical schools, offering opportunities to medical students to observe and take part in various phases of the Department's work. Each summer, a three months' training program for approximately eight students has been offered. It aims to acquaint the student with the purposes and methods of Public Health and to afford him some early practice and responsibility. Like other specialties, Public Health has its own techniques. In medical school, the student learns to study sick individuals, arrive at a diagnosis and plan treatment, or to advise on the preservation of health. This experience in Public Health demonstrates how the public health worker serves a community, made up of individuals. The evidence of the needs of the community, its "signs and symptoms," is observed in new ways. Methods are different, but the fundamental processes of study, diagnosis and treatment on the one hand and of prevention on the other, remain. With community, as with individuals, public relations are important.

The students are assigned singly or in pairs to each of several training counties and the City Health Department. Under the guidance of the County Health Officer they become acquainted with all major fields of the Department's activities, such as Sanitation, Maternal and Child Hygiene, Communicable Disease work, including tuberculosis, Mental Health activities, work with crippled children and their rehabilitation, problems of elderly and sick people, their placement in Chronic Disease Hospitals and nursing homes and the administration of the Home Medical Care Program. The students observe the Health Officer, accompany Public Health Nurses and sanitarians in their field work, attend community meetings and help in clinics. Toward the end of the summer, they participate as a group in a seminar, which, as a rule, is conducted with the help of a member of the staff of the Johns Hopkins School of Hygiene. At this seminar students present a paper on the results of studies which have been conducted during their course under the Health Officer's guidance. Members of the Department and other invited guests discuss the student's findings with him. Sometimes special arrangements are made for periods of observation and training in Mt. Wilson State Hospital (tuberculosis), Montebello State Hospital (Chronic Diseases) or the Central Office. Participants this year included:

Student's Name	*Medical School*	*Training County or Division*
John S. Harshey, Sophomore	University of Maryland	Harford County Health Department
George W. Rever, Junior	University of Maryland	Baltimore County Health Department
Adrian S. Weyn, Sophomore	University of Maryland	Washington County Health Department
Fortune Odend'hal, Freshman	University of Maryland	Washington County Health Department
Douglass Shepperd, Sophomore	University of Maryland	Baltimore City Health Department
James J. Kelson, Sophomore	University of Maryland	Anne Arundel County Health Department
William G. Bartlett, Sophomore	University of Maryland	Montgomery County Health Department
Elmer S. McKay, Freshman	University of Maryland	Central Office
Norman P. Jones	University of Maryland	Montebello State Hospital
Herbert L. Kronthal	University of Maryland	Montebello State Hospital
Milton L. Engnoth	University of Maryland	Montebello State Hospital
James L. Beeby	University of Maryland	Montebello State Hospital
George Mitchell	George Washington University Medical School	Montgomery County Health Department



STATE OF MARYLAND DEPARTMENT OF HEALTH

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, September 1–27, 1956

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS: Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County	5	—	2	—	1	—	8	2	1	—	2	—	—	1	17	—	3	m-2	6
Anne Arundel	—	—	2	—	—	—	1	3	—	—	—	—	—	—	3	—	2	—	1
Howard	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	2	—	—
Harford	—	—	—	—	—	—	1	1	—	—	—	—	—	—	3	—	—	m-1	—
Carroll	—	—	—	—	1	—	—	—	—	—	—	—	—	—	1	—	—	m-1	1
Frederick	—	—	—	—	—	—	—	2	—	—	—	—	—	—	—	—	4	—	2
Washington	—	—	—	—	—	—	—	2	—	—	—	—	—	—	5	—	—	—	1
Allegany	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Garrett	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Montgomery	—	—	1	2	1	—	12	—	1	—	3	—	—	—	9	—	—	* m-1	1
Prince George's	—	—	—	—	—	—	7	4	—	—	—	—	—	—	8	—	4	m-2	—
Calvert	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—	—
Charles	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1
Saint Mary's	2	—	—	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—	1
Cecil	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	1	—	1
Kent	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Queen Anne's	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Caroline	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Talbot	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	1
Dorchester	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Wicomico	1	—	—	1	6	—	—	—	—	—	—	—	—	—	—	—	5	e-1	1
Worcester	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	1
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—	—	1
Total Counties	8	0	5	3	9	0	32	14	2	0	5	0	0	1	55	3	25		20
Baltimore City	19	0	11	1	16	0	29	9	5	0	3	0	0	11	70	13	554		9
State																			
September 1–30, 1956	27	0	16	4	25	0	61	23	7	0	8	0	0	12	125	16	579		29
Same period 1955	10	1	9	19	20	0	35	27	27	2	14	3	0	25	160	18	618		37
5-year median	15	1	9	13	33	1	32	80		3	19	3	2	49	174	19	652		33
Cumulative totals																			
State																			
Year 1956 to date	2455	1	1079	78	9242	43	2607	54	11	14	670	15	6	119	1543	200	5277		512
Same period 1955	2082	11	455	296	1488	21	1471	115	79	22	2186	19	0	317	1518	145	5539		479
5-year median	3043	13	672	307	5558	50	1957	171		32	1351	22	18	389	1816	165	5481		464

e = encephalitis, possibly Eastern Equine Type, lab. proof not available.
m = meningitis, other than meningococcus.
* = malaria, contracted outside the U. S. A.

BALTIMORE CITY HEALTH DEPARTMENT

The Changing Structure of Baltimore's Population

In his *Saturday Letter to the Mayor*, the Commissioner of Health of Baltimore on August 3 wrote as follows:

"You will be interested in the summary of the vital statistics of the city for the first six months in 1956 as issued today by Dr. Matthew Tayback, Director of the Statistical Section of the City Health Department, as follows:

"The control of such communicable diseases as typhoid fever, diphtheria and whooping cough continues to hold the incidence of these conditions to near extinction levels. Thus, in the period January–June, 1956, there were no cases of diphtheria reported, one case of typhoid was reported and a new low for this period of 28 cases of whooping cough was recorded. The incidence of poliomyelitis during the first six months of the year is normally low. Nevertheless, it is gratifying to report that no cases of this disease occurred among city residents within the first half of 1956. For the same period in 1955, there were 5 cases reported.

"The control of tuberculosis, one of the more difficult problems which confront public health authorities in the major cities of this country, remains a difficult area of work. In 1955, a decline of 14 per cent was noted in the newly reported cases of tuberculosis as compared to 1954. For the first six months of this year, 609 new cases were reported as compared to 608 for the equivalent interval in 1955. This would seem to suggest that the decline observed in 1955 was a true downward movement in the incidence of tuberculosis but that efforts to control this disease as a cause of morbidity must be persistently and effectively maintained.

"A study of the trend in births reveals interesting clues on the changing structure of the population. In the first six months of 1956 there were 6,552 white live births as compared to 6,954 for the same interval in 1955 and 7,150 for 1954, which is indicative of a consistent decline.

"The trend in nonwhite births has been quite the reverse. Thus, in the first six months of 1956 there were 4,544 births; in 1955 there were 4,234 births, and in 1954 there were 3,900 births. These trends, consistent with such other evidence as the school registration data, demonstrate that the white city population is declining as a result of outmigration to the surrounding counties and the nonwhite population is increasing, the net effect being a relatively stable total population level but one of changing racial composition. From a public health point of view, a rapidly rising nonwhite population suggests the needs for increasing well baby health services for this group, and more important, points to the severe disparity which is developing between the number of physicians serving the nonwhite population and their rapidly increasing medical needs resulting from population growth.

"The migratory patterns which are apparent in Baltimore tend to magnify the normal aging pattern which has been noted throughout the country. Thus in the white population, the net outmigration trend has a tendency to remove selectively young couples and their children thus increasing the proportion of older persons in the stable white population remaining in the city. The Health Department has charted this movement carefully and is seeking to keep abreast of recent developments on public health services for the aging.

"The low infant mortality rates achieved in recent years among white children were maintained in the first half of 1956. There were 22.2 deaths per 1,000 infants born in this period, the same figure as was recorded in 1955. Infant mortality rates estimated for colored children were 36.7 in 1956, close to the same level of 37.6 as experienced in the first half of 1955.

"For the separate causes of death, the chief changes noted are: (1) an increase in mortality from accidents, 282 deaths recorded in 1956 as compared with 232 in 1955 for the first half year; and (2) an increase in mortality from pneumonia and influenza, the number of deaths from this being 194 for the first six months of 1956 and 153 for the same period in 1955.

Very truly yours,

Huntington Williams, M.D.

Commissioner of Health."

Ancillary News

PHARMACY SECTION

MARYLAND PHARMACEUTICAL ASSOCIATION

650 West Lombard Street,
Baltimore 1, Md.
SA 7-0746

THANK YOU DOCTOR*

The Baltimore Retail Druggists' Association and the Maryland Pharmaceutical Association wish to thank the members of the Medical and Chirurgical Faculty of Maryland for visiting the Pharmacy Exhibit at the Convention of the Medical and Chirurgical Faculty held in Baltimore, May 2, 3 and 4, 1956.

We, as pharmacists, are grateful for the opportunity afforded us to meet with you and discuss mutual problems between medicine and pharmacy.

One of the most vexing problems confronting our two professions today is the refilling of prescriptions calling for "legend" drugs. By legend we mean those drugs bearing the phrase, "Caution-Federal law prohibits dispensing without prescription."

The Durham-Humphrey Law gives the physician complete authority to state on the prescription whether it may be refilled or not. If this information is not placed on the original prescription, the pharmacist has no authority to do so without first consulting the prescriber for his permission to refill the prescription. The only exception are those prescriptions calling for Narcotic drugs—a new prescription, either oral or written, must be issued each time and refills can not be indicated. Indication of whether the prescription may or may not be refilled on the original prescription will save both the prescriber and his patient from annoyance and inconvenience. Pharmacy's exhibit therefore, was devoted to the subject of refills, because it is our devoted purpose to serve the public and the physician with minimum interference of any kind toward a smooth functional health performance.

If you wish any further information regarding the subject of refills, those Narcotic drugs that may be prescribed orally, or for that matter, any other information concerning the handling of drugs, please do not hesitate to consult "Your Best Neighbor," your neighborhood pharmacist. The pharmaceutical associations are also at your service.

In happy conclusion, we are pleased to announce the clock-radio prize offered by the Pharmacy Exhibit, was won by Doctor John G. Ball, Bethesda, Maryland. We trust the good doctor will have an enjoyable musical time.

*Professional Relations Committee of the Maryland Pharmaceutical Association.

Blue Cross - Blue Shield

ALTERNATIVE BLUE SHIELD PROGRAM PROPOSED

R. H. DABNEY*

When we say that Blue Cross and Blue Shield are community health programs, we mean that both Plans are sponsored at the source of health care. For Blue Cross, this means our general hospitals. For Blue Shield, it is the medical profession. Individual physician sponsorship, through participating agreements, offers to subscribers and physicians alike certain unique features without which Blue Shield would lose its special identity in the field of prepayment health programs.

The basic obligation for Blue Shield, as for Blue Cross, is to enroll as many people in the community as possible, and to make available broad health care benefits at the lowest possible cost. The programs exist solely to meet the community needs. As membership grows, and as medical science continues to change and advance, so must the Blue Shield program grow and increase its scope of coverage. In large part, this is the responsibility of the medical profession through its appointed representatives. The Plan itself is simply the agent through which the program is made available to the public; its responsibility is primarily administrative.

In November 1950, Blue Shield in Maryland enrolled its first subscriber. Early experience revealed certain flaws in the program and, consequently, in the fall of 1951, just a year after operations began, the program of benefits and the fee schedule were re-evaluated. As a result of this study, changes were made in the Plan effective September 1952.

In May 1956, Blue Shield again undertook a change in its benefits and fee schedule, broadening and expanding its services. This revision was made in conjunction with changes in the Blue Cross program.

Through all these changes in the Blue Shield program, the basic service benefit provision has remained unchanged. This feature, which provides for acceptance of the Blue Shield fee as payment in full for services to subscribers whose annual income is below specified amounts, is perhaps the most important single feature in Blue Shield. Herein lies the basic element of sponsorship by the medical profession.

Our present Blue Shield program is geared to income levels of $3,000 a year for an individual and $4,000 a year for a family. To subscribers whose annual incomes fall below these levels, the participating physician agrees that he will make no additional charge beyond the established fee for services covered under the program. When these income levels were established, they were felt to be adequate and realistic in terms of average family incomes in Maryland, and it was estimated that approximately 75% of the subscribers would be eligible under this service provision. As all of us know, the last several years have seen a continuous rise in general salary and wage figures, and we now estimate that the income provision is applicable to less than 50% of Blue Shield subscribers. This simply means that the "service" feature has diminished in value to many subscribers and groups. There is an increasing demand for a program offering a higher schedule of benefits and higher income levels, and we believe that this demand can only be met through the introduction of a second Blue Shield program.

In proposing a new program to supplement the present plan, we will be following the lead of many of the larger Blue Shield Plans in other parts of the country—in Massachusetts, Michigan, New York City, Pennsylvania, and Virginia, to name a few. The new plan would have higher income levels ($4,000 for an individual and $6,000 for a family), a higher fee schedule, and, of course, higher subscription charges.

As a first step toward the development of this new program, last summer we mailed a letter and questionnaire to all participating doctors, requesting their assistance and advice in the development of a new fee schedule. The response to our request was most gratifying. We received about 1,000 replies, and the information will be of tremendous value to our Medical Relations Committee in setting up the new fee schedule in proper relationship to the present one. There are many administrative details yet to be worked out, but it is our hope that we will be able to inaugurate the new program before the end of 1956.

* Director, Maryland Hospital Service, Inc., Maryland Medical Service, Inc.

Book Reviews*

Acknowledgement of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them.

Problems in Amoebiasis. Charles William Rees, Ph.D. Charles C. Thomas, Publisher, Springfield, Illinois, 1955.

Even though amoebiasis as an infection has been recognized since 1875, there are still many uncertain and unknown features of the organism Entamoeba histolytica and the disease. In an effort to separate facts from opinions, emphasize known laboratory techniques, and suggest methods of approach to gain more knowledge, Dr. Rees has collected and concentrated much of the known basic information concerning Entamoeba histolytica in this treatise.

One major overshadowing consideration has been the role of Entamoeba histolytica in the etiology of amoebiasis, for there are some investigators who feel that the organism is not the sole cause of the disease. Of parallel importance has been the pathway of a cyst or cysts from an infected to a susceptible individual. Dr. Rees discusses these problems and the laboratory demonstration of amoebiasis infestation in detail.

In this brief treatise, Dr. Rees has gathered together the basic science and laboratory knowledge about Entamoeba histolytica. He has evaluated this information critically and has suggested methods for further investigation. His thoughts have been aimed primarily to laboratory investigators and students of amoebiasis. He has accomplished this aim very well and may have accomplished it better by the addition of several more illustrations.

W. C. E.

Obstetric Practice. Harold Speert, M.D. and Alan F. Guttmacher, M.D. McGraw-Hill Book Company, Inc., Publishers, Copyright, 1956.

The obstetrical literature has lacked for years an up-to-date handbook in which extraneous material, such as statistical data, theoretical considerations and the basic concepts of anatomy, etc., have been omitted. With a wealth of experience behind them, Doctors Speert and Guttmacher have successfully filled this lack. There are no figures, photographs, drawings or footnotes. A practical up-to-the-minute analysis of obstetrical practice is presented in a nicely concise form.

The format of the book is complete except for the items mentioned above. It is well bound and printed in comparatively large print, making for easy reading. Individual problems are frequently attacked by the 1, 2, 3, method of presentation, as well as other diagrammatic forms.

This volume can be recommended for its soundness, ease of reading, completeness of essentials and its straightforwardness. It is for the practicing obstetrician, whether he be general practitioner or specialist, as a reference for sound concepts of management of obstetrical normalities and complications.

D. F. K.

New and Nonofficial Remedies Evaluated by the Council on Pharmacy and Chemistry of the American American Medical Association. J. B. Lippincott Company, Philadelphia, 1956.

New and Nonofficial Remedies makes its annual appearance containing an ever-increasing list of new drugs that have been accepted by the Council on Pharmacy and Chemistry as recognized in the treatment and diagnosis of disease. Of special interest to practicing physicians are the monographs on therapy which accompany the drugs admitted to this compendium. These monographs are precise, accurate and conservative. In this respect this volume differs from the Pharmacopeia and the National Formulary, which do not contain monographs on the therapeutic usefulness of drugs. To mention only a few, there are excellent monographs on the use of radioactive isotopes, contraceptives, and adrenal corticosteroids and rauwolfia preparations. The reviewer is strongly of the opinion that with the ever-increasing family of new drugs becoming available, New and Nonofficial Remedies is a necessary addition to every physician's library.

J. C. K., Jr.

*The reviews here published have been prepared by competent authorities and do not represent the opinions of any official bodies unless specifically stated.

Coming Meetings

OTOLARYNGOLOGICAL SECTION*

THEODORE A. SCHWARTZ, M.D., *Chairman* ALVIN P. WENGER, M.D., *Secretary*

Tuesday, November 6, 1956

Johns Hopkins Club, Homewood Campus

Dinner Meeting 6:00 p.m.

Correction of the Deviated Nose. IRVING B. GOLDMAN, M.D., Associate Laryngologist in Charge of Rhinoplasty, Mt. Sinai Hospital, New York City

SECTION ON DISEASES OF THE CHEST*

WARDE B. ALLAN, M.D., *Chairman* EDMUND G. BEACHAM, M.D., *Secretary*

Wednesday, November 7, 1956, 8:00 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Long Term Follow-Up of Far Advanced Pulmonary Tuberculosis Treated by Chemotherapy (Illustrated.) M. W. JACOBSON, M.D. AND E. G. BEACHAM, M.D.

PEDIATRIC SECTION*

SAMUEL S. GLICK, M.D., *Chairman* HARRY H. GORDON, M.D., *Secretary*

Tuesday, November 13, 1956, 8:30 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Modern Day Rickets. ROBERT E. COOKE, M.D.

Discussion by HAROLD E. HARRISON, M.D.

This meeting serves as a welcome to Dr. Cooke, Professor of Pediatrics, The Johns Hopkins University School of Medicine.

OPHTHALMOLOGICAL SECTION*

HERMAN K. GOLDBERG, M.D., *Chairman* CHARLES E. ILIFF, M.D., *Secretary*

Thursday, November 15, 1956

Dinner Meeting, 6:30 p.m.

Johns Hopkins Club, Homewood Campus

DR. IRVING H. LEOPOLD, Assistant Professor of Ophthalmology, University of Pennsylvania Graduate School of Medicine, Philadelphia, will be the guest speaker

* Sections of the Baltimore City Medical Society.

MATERNAL MORTALITY COMMITTEE

HUNTINGTON WILLIAMS, M.D., *Chairman* IRVIN M. CUSHNER, M.D., *Secretary*

Thursday, November 29, 1956, 4:00 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and Baltimore City Health Department

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

RICHARD W. TELINDE, M.D., *Chairman* BEVERLEY C. COMPTON, M.D., *Secretary*

Thursday, November 15, 1956, 5:00 to 6:00 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty of the State of Maryland

STATE DEPARTMENT WORKING ON ITS DEPENDENTS MEDICAL CARE BILL

AMA Washington Letter 84–85

State Department officials are working on regulations to carry out a new program of medical care for Foreign Service dependents living abroad. The program which is estimated to involve about 13,500 dependents at this time was authorized by Congress in a bill to make a career in the Foreign Service more attractive. It is expected that the bulk of the care will be provided in U.S. military installations by physicians in the services.

It may foreshadow an extension of such care to all federal civilian employees and their families stationed overseas, a total currently estimated at around 65,000. The House Civil Service Committee has asked the Civil Service Commission and other agencies with substantial numbers of overseas employees to review policies "to insure that, to the extent possible, the services are made available to all . . . on a substantially equal basis."

The Foreign Service program (P. L. 828) provides (1) full payment by the government of medical expenses of employees whether in or outside a hospital, (2) the same care for dependents but with the first $35 for each illness to be paid by the employee, (3) authorization for insurance or private health plans for dependents, with premiums paid by the government and (4) payment of cost of transportation for moving dependents to nearest suitable hospital or clinic.

Up to 120 days of hospitalization or equivalent care for each dependent illness or injury are allowed, and this may be extended by the Secretary of State where it is found by medical advice that the illness was caused by having lived abroad.

Important Reminder

ENROLLMENT IN BLUE CROSS AND BLUE SHIELD

for

MEMBERS OF THE MEDICAL AND CHIRURGICAL FACULTY

November 1956

The annual Blue Cross and Blue Shield enrollment for you and your employees occurs in November. During this enrollment period, applications will be accepted for new memberships and for changes in present coverage. In October, before the enrollment period begins, you will receive application cards and full information on the enrollment. November is the only time that Maryland Medical Service, Inc., and Maryland Hospital Service, Inc., will accept applications for insurance in Blue Cross and Blue Shield. These applications must be in their office, 200 W. Baltimore Street, Baltimore 1, by NOVEMBER 20, 1956.